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In The Supreme Court of The United States

OCTOBER TERM, 1997

No.

JACK ECKERD CORPORATION, PETITIONER

v.

THOMAS SHANNON, RESPONDENT.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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QUESTION PRESENTED FOR REVIEW

WHETHER THE ELEVENTH CIRCUIT ERRED IN AFFIRMING THE DISTRICT COURT, WHICH, AFTER FINDING THAT THE PETITIONER HEALTH BENEFITS PLAN HAD ACTED ARBITRARILY AND CAPRICIOUSLY IN DENYING THE RESPONDENT BENEFITS FOR A PANCREAS TRANSPLANT ON THE GROUNDS THAT THE PROCEDURE WAS EXPERIMENTAL AND/OR INVESTIGATIONAL AND REMANDING THE MATTER TO THE PLAN FOR FURTHER DETERMINATION, ERRED IN DIRECTING THE PLAN ON REMAND TO CONSIDER EVIDENCE AVAILABLE UP TO THE DATE OF ITS DECISION ON REMAND RATHER THAN AT THE TIME THE PLAN MADE ITS ORIGINAL DECISION, SUCH THAT THE ELEVENTH CIRCUIT'S DECISION IS IN CONFLICT WITH THE DECISIONAL LAW OF THE EIGHTH CIRCUIT.

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In The Supreme Court of The United States

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No.

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v.

THOMAS SHANNON, RESPONDENT.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

The Petitioner, JACK ECKERD CORPORATION, petitions this Honorable Court for a writ of certiorari to review a judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (App. 20-23) is reported at 113 F.3d 208 (11th Cir. 1997). The decisions and orders of the United States District Court for the Southern District of Florida are not reported (App. 1-19).

STATEMENT OF JURISDICTION

This Court has jurisdiction of this matter pursuant to 28 U.S.C. § 1254, since it involves review of a Final Judgment of the United States Court of Appeals for the Eleventh Circuit, affirming a judgment of the United States District Court for the Southern District of Florida, based on the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. The Eleventh Circuit rendered its original judgment on May 29, 1997, and denied Petitioner's Petition for Rehearing and Suggestion of Rehearing *En Banc* on September 4, 1997. The Eleventh Circuit's decision in this case is in direct conflict with the Eighth Circuit Court of Appeals' decisions in *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (1993) and *Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569 (8th Cir. 1992).

STATUTORY PROVISIONS INVOLVED

Section 1132 (a)(1)(B) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1132 (a)(1)(B) provides as follows:

> A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> (B) to recover benefits due him under the terms of his plan, to

enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan;

STATEMENT OF THE CASE

This action arose out of the denial of Respondent Thomas Shannon's ("Shannon") request for pre-authorization of benefits for the pancreas portion of a simultaneous kidney/pancreas transplant by the employee group health benefits plan of Petitioner (App. 1-2). Respondent is a beneficiary of the Jack Eckerd Corporation Health Benefits Plan ("the Plan"), which is a self-funded group employee health benefits plan, an employee welfare plan as defined in ERISA, 29 U.S.C. § 1002(1). At the time of the events giving rise to this lawsuit, the Plan provided, in relevant part:

> (t) Charges associated with organ transplants will be covered as follows:
>
> (I) The Plan will pay the regular portion of medically necessary reasonable and customary hospital and medical expenses related to the transplant of medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient.
>
> Transplants that are experimental/investigative as determined by the Plan Administrator are not covered.

(A.12).

The Plan was Shannon's secondary health benefits provider. Medicare was his primary source of health benefits coverage. Shannon has long-term diabetes mellitus Type I. As a result of his kidney failure, Shannon was advised by his treating nephrologist, Dr. David Hoffman, to undergo a kidney transplant. Shannon on his own

investigated the possibility of a simultaneous pancreas transplant and decided to have one done at the University of Minnesota, which agreed to perform the procedure (or at least to put Shannon on the cadaveric transplant list) if Shannon could come up with sufficient funding.

On August 16, 1990, Shannon, through the transplant surgeon at the University of Minnesota who would be performing Shannon's simultaneous kidney/pancreas transplant, at the University of Minnesota, initiated with the Plan on Shannon's behalf a request for pre-certification review and determination of benefits for the simultaneous kidney/pancreas transplant (App.1). The Plan considered Shannon's request in concert with a request for additional information from the surgeon, as well as input on the clinical efficacy of the procedure from its quality assurance/ utilization reviewer, Cost Care, Inc. CCI informed the Plan that pancreas transplants were medically investigational (App. 2-3). The Plan in turn informed Respondent that, while the Plan would cover expenses associated with the kidney transplant, it could not cover expenses associated with the pancreas transplant inasmuch as experimental or investigational procedures were excluded from Plan coverage (App. 3).

Thereafter, Shannon's surgeon sent an appeal to the Plan, enclosing medical journal articles on pancreas transplantation, which the Plan reviewed and sent on to Cost Care. CCI subsequently forwarded to the Plan its written medical opinion which stated that pancreas transplants were medically investigational and may well be considered "within the realm of experimental." (App.3).

The Plan Administrator additionally contacted another health insurance plan provider, and learned that it, too, considered pancreas transplantation to be experimental and not a covered procedure. The Administrator was also aware that Medicare was Shannon's primary health care benefits provider, and that Medicare refused to cover pancreas transplants because Medicare considered the technology experimental or investigational. (App. 2-3). Based upon CCI's medical analysis and recommendation that the pancreas transplant technology was clinically investigational, if not experimental; the

information which the Plan had received from the health carrier; and the knowledge that Medicare considered the procedure investigational or experimental, the Plan determined that the pancreas transplant was excluded from Plan coverage as investigational, and so notified Shannon (App. 3).

Shannon filed another appeal of the Plan's denial of the request for pre-authorization benefits for a pancreas transplant, but enclosed no new information. In response to the appeal, the Plan further investigated how other benefits administrators in the community dealt with pancreas transplants. Petitioner reaffirmed that the first benenfits provider which it had contacted did indeed consider pancreas transplant technology to be investigational and thus excluded from coverage. The Plan then contacted four additional health benefits providers, all of which stated that they considered the procedure to be experimental and not covered (with the exception of one which covered it "under some circumstances") (App.4). As a result, the Plan stood by its initial denial of Shannon's pre-certification request for benefits for the pancreas portion of his transplant. Respondent nevertheless underwent the pancreas/kidney transplant at his own cost, and the pancreas graft failed (App. 5).

The instant lawsuit followed. The United States District Court for the Southern District of Florida held that the Plan had acted arbitrarily and capriciously in making its coverage decision (App. 12, 15). The court remanded the matter back to the Plan for further consideration , with directions to "make a reasonable inquiry into all pertinent evidence available up to the date of [the decision on remand]." (App. 15, 17). The Plan took an appeal to the Eleventh Circuit, which was dismissed for want of jurisdiction, as the court held that the order of remand was not a final appealable order. *Jack Eckerd Corp. v.Shannon,* 55 F.2d 561 (11th Cir. 1995). In the meantime, the Plan did as the district court had instructed. As a result of evidence available at the time of the re-review, which was three (3) years after Respondent's request for benefits, the Plan determined that, ***under current standards***, the pancreas transplant was no longer medically experimental or investigational. The Plan noted that neither Respondent nor his physicians had submitted any new evidence as to the clinical efficacy of the procedure, but that its medical consultant

had stated that the *current* clinical data suggested the technology had advanced from the realm of experimental/investigational. Similarly, in checking with other health benefits providers which three (3) years before had refused to cover pancreas transplants because they considered the procedure experimental or investigational, the Plan learned that they, too, had begun to provide coverage for pancreas transplants ***under current standards***. Nevertheless, the Plan declined to pay Shannon any benefits because at the time he made his claim, the procedure was experimental/investigational, and thus not covered (App. 25). The district court ultimately entered a judgment on Respondent Shannon's behalf for the amount of the benefit, plus attorney's fees and costs, with pre-judgment interest (App. 19). The Eleventh Circuit affirmed (App. 20-23).

REASONS FOR GRANTING THE PETITION

Even assuming *arguendo* that the Eleventh Circuit was correct in affirming the district court's finding that the Plan acted arbitrarily and capriciously in denying Respondent Shannon benefits for the pancreas transplant and remanding the matter to the Petitioner Plan for reconsideration, the appellate court nevertheless erred in affirming the district court's directions to the Plan to consider on remand evidence available after the date of the Plan's original coverage decision. The Eleventh Circuit's decision is squarely in conflict with the decisional law of the Eighth Circuit, notably the decisions in *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (1993) and *Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569 (8th Cir. 1992). In *Bernards*, the Eighth Circuit was confronted with an ERISA plan which had provided inadequate explanation for its coverage decision in a life and death matter. The court held that remand is the appropriate course of action when an ERISA plan's action lacks adequate explanation such that a reviewing court must seek fuller explanation before it can apply the deferential arbitrary and capricious standard of review. The Eighth Circuit's opinion makes clear, however, that the remand is to take place in the context of the evidence presented at the time of the request:

> To conduct meaningful review in these [emergency] circumstances, the district court must obtain from

> United a further explanation of its decision, afford Bernards the opportunity to present evidence challenging the decision..., and then apply the deferential standard of review to the expanded record.

987 F.2d at 488. Similarly, in another remand situation, the Eighth Circuit held:

> We have previously noted that, in order to properly apply the deferential standard of review, a reviewing court must be provided the rationale underlying the trustee's decision. [emphasis added].

Cox v. Mid-America Dairymen, Inc., 965 F.2d 569, 573 (8th Cir. 1992). In *Cox*, the court was faced, as was the Eleventh Circuit in the instant case, with a situation where the plan did not adequately explain its canvasing and assessment of the evidence which it had before it. In neither *Cox* nor *Bernards* was the ERISA plan directed to consider evidence which may have developed in a lengthy period of time between the time of the participant or beneficiary's benefits claim and the time of remand. Rather, the Eighth Circuit's decisions make it clear that the remand is only for the purpose of the plan being able to better explain and, if need be, to reconsider the evidence that it had before it at the time it made its original decision.

The Eighth Circuit's approach is the correct one and represents the majority view of courts which have had occasion to reach this issue. This approach recognizes that medical science is a dynamic process, and what may be experimental today may be accepted therapy tomorrow. As the Northern District of Illinois held in *Estate of Goldstein v. Fortis Benefits Co.*, __F.Supp. __, 1996 WL 18977 (N.D. Ill. 1996):

> At some point, the body of scientific evidence gathered establishes that a procedure is or is not effective; at that point, it is presumably no longer experimental. Clinical research is ongoing and even the most tried and true procedures are constantly being re-evaluated. A line is eventually crossed,

> however, and a procedure becomes recognized and accepted within the medical community.

Accord: *Bushman v. State Mutual Life Assurance Co. of America*, 915 F.Supp. 945, 953-954 (N.D. Ill. 1996) ("Today's experiment may well be tomorrow's cure.")

Any reconsideration of the Petitioner Plan's benefits decision must therefore necessarily be restricted to evidence known at the time when the initial coverage decision was made. This is so because the state of the art of pancreas transplants when Respondent applied for pre-certification was all that the Plan had available to it for consideration. In order to provide meaningfully deferential review, therefore, the court could only request the Petitioner Plan to revisit and reconsider that evidence which it had available to it at the time it made its original coverage decision. *See, e.g., Nesseim v. Mail Handlers Benefit Plan*, 995 F.2d 804, 807 (8th Cir. 1993); *Holder v. Prudential Insurance Company of America*, 951 F.2d 89, 91 (5th Cir. 1992); *Denton v. First National Bank of Waco, Texas*, 765 F.2d 1295, 1304 (5th Cir. 1985). As the Fourth Circuit held in *Sheppard & Enoch Pratt Hosp. Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 125 (4th Cir. 1994):

> We continue to adhere to the view expressed in Berry that an assessment of the reasonableness of the administrator's decision must be based on the facts known to it at the time. Thus, although it may be appropriate for a court conducting a *de novo* review of a plan administrator's action to consider evidence that was not taken into account by the administrator, the contrary approach should be followed when conducting a review under either an arbitrary and capricious standard or under the abuse of discretion standard.

Even the Eleventh Circuit has recognized the wisdom of this approach. *See, e.g., Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989).

This confinement of remand to consideration of evidence

available at the time when the coverage decision was first made is all the more appropriate when it is considered that Petitioner actually had the surgery in June 1991, and that it failed (App. 5). A remand that considers information available now (or even three (3) years after Shannon's request), but not available to the Plan administrator at the time her decision was made, unfairly burdens the Plan with the possibility of paying for a procedure which was investigational at the time it was requested and therefore excluded from coverage, but is no longer. The district court's decision, and the affirmance by the court of appeals, simply fails to account for the constantly changing nature of medical science.

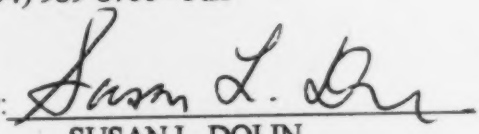
The district court relied upon the District Court of Connecticut's decision in *Bucci v. Blue Cross/Blue Shield of Connecticut*, 764 F. Supp. 728, 732 (D. Conn. 1991) for its determination that the Plan must take account of after-acquired evidence in its decision on remand. The Eleventh Circuit concluded that the district court had acted reasonably in doing so (App. 23). However, the *Bucci* court was not dealing with a remand situation. Nor does the *Bucci* court cite any supporting authority for its conclusion that a benefits denial is continuing and must be measured by currently available information, even though a final determination has been made. Indeed, applying the *Bucci* court's reasoning to a remand situation such as the instant case clearly contravenes the pronouncement in *Bernards, Cox, Jett, Nesseim,Holder, Sheppard & Enoch Hosp.* and *Denton* that deference be afforded to plan administrators' decisions, rather than have such decisions imposed upon the plan by the federal courts. *Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486 (1993); *See also, Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569 (8th Cir. 1992), (proper course is for court reviewing plan administrator's coverage decision under arbitrary and capricious standard to remand to plan administrator for explanation of why decision was made based on evidence before it at the time and then apply deferential standard to explanation); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 427 (7th Cir. 1988) (Posner J. concurring and dissenting) (issue limited to deciding whether in vitro fertilization was still an experimental procedure at time claim was made); *Berry v. Ciba-Geigy Corporation*, 761 F.2d 1003, 1007 (4th Cir. 1985) (court may not put forth evidence that the plan administrator might have

considered but did not); *Esdale v. American Comm. Mutual Ins. Co.*, 914 F.Supp. 270 (N.D. Ill. 1996) (same). The Plan on remand in the instant case did exactly as the Eighth Circuit directed in *Bernards* and determined that, based on the evidence available at the time, its coverage decision was correct . However, in accordance with the district court's directive, the Plan went even further and acknowledged the progression of pancreas transplant technology from the realm of investigational to accepted therapy, *albeit three years after Shannon made his request.* The operative time frame, however, is not three years down the road; it is, as the courts have made clear, the time the original request was made. Therefore, the district court's directions on remand were clearly wrong as a matter of law. *Cf., Bechtold v. Physicians Health Plan of Northern Indiana, Inc.*, 19 F.3d 322 (7th Cir. 1993) (recommendations of change in plan coverage to keep up with pace of medical advances was beyond authority of reviewing medical committee). The Eleventh Circuit's affirmance of the district court was also legally in error.

CONCLUSION

In light of the foregoing, Petitioner Jack Eckerd Corporation respectfully requests that this Honorable Court grant its petition for a writ of certiorari.

Respectfully submitted,
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APPENDIX
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff,

v.

JACK ECKERD CORPORATION,

Defendant

_____/

FINDINGS OF FACT
AND CONCLUSIONS OF LAW

This Cause was tried before this Court during the week of September 21, 1992. This is a lawsuit brought by Plaintiff Thomas Shannon ("Shannon") pursuant to the Employment Retirement Income Security Act ("ERISA"), 29 u.s.c. § 1132(A)(1)(b), to recover benefits for a simultaneous kidney/pancreas transplant performed in 1991 and a new pancreas transplant which has not yet been performed. Having carefully considered the evidence properly taken, the Court hereby makes the following findings of fact and conclusions of law:

FINDINGS OF FACT

In June, 1990, Shannon was diagnosed by Dr. David E.R. Sutherland, one of the leading authorities in the country on pancreas transplants, as suffering from renal disease secondary to diabetes. On behalf of Shannon, Dr. Sutherland sent a letter dated August 16, 1990 to Gail Azem--a Registered Nurse and Defendant Jack Eckerd Corporation's ("Eckerd") Health Claims Specialist--requesting that Eckerd issue prior authorization for benefits under the Jack Eckerd

Corporation Health Plan ("the Plan") for Shannon covering a combined kidney/pancreas transplant, all hospital and medical expenses required for the prescribed procedure, and future post-surgical benefits. Plaintiff's Exhibit 8.

In response to Dr. Sutherland's letter of August 16, 1990, Gail Azem advised Dr. Sutherland in a telephone conversation that took place sometime between August 16, 1990 and September 7, 1990 that Eckerd would pay for the kidney but not the pancreas transplant. Dr. Sutherland subsequently sent a letter dated September 7, 1990 to Gail Azem stating that he "would like to formally appeal the ruling in regard to the pancreas transplant..." Plaintiff's Exhibit 1. The letter indicated that, in Dr. Sutherland's experience, numerous insurance companies have provided coverage for pancreas transplants. Dr. Sutherland attached to the letter both a number of articles from the medical literature detailing the efficacy of pancreas transplants and a list of insurance companies that, in his experience, covered pancreas transplants and did not consider the procedure investigational. Eckerd treated the letter as a request for an explanation of a denial of benefits pursuant to Plan section 8.2.

Ms. Azem forwarded Dr. Sutherland's letter and attachments to Cost Care, Inc. ("Cost Care") for consideration. Cost Care is a medical review organization which employs physicians, nurses, and other health professionals to review the medical aspects of particular insurance claims. The Plan engaged Cost Care to render medical advice concerning benefits claims filed by Plan participants.

On September 21, 1990, Cost Care faxed to Eckerd its report concerning the medical status of pancreas transplants. At some time between September 7, 1990 and October 11, 1990, the Plan Administrator contacted Prudential Insurance Co. ("Prudential"), one of the companies on the list attached to the Sutherland letter of September 7, 1990, and inquired whether Prudential covered pancreas transplants. The Plan Administrator was informed that Prudential did not cover the transplants because the company considered the procedure to be investigational. The Plan Administrator, however, never inquired as to Prudential's definition of the term "investigational" or the criteria that Prudential used to determine that the pancreas transplant procedure met this definition.

The Plan Administrator, through Gail Azem, sent a letter dated October 11, 1990 to Dr. Sutherland explaining Eckerd's basis for denying Shannon's claim. Plaintiff's Exhibit 2. The letter closely parallels the report faxed by Cost Care to Eckerd on September 21, 1990 and indicates that Eckerd initially denied Shannon's claim for a pancreas transplant on the basis of medical evidence that the overall survival rate of patients who underwent combined kidney/pancreas transplants was comparable to that of patients who underwent only kidney transplants. The letter also states that this finding was based on data limited to one year post-transplant because data concerning survival rates at two to three years post-transplant was not provided. Finally, the letter points out that the American Medical Association ("AMA") and Medicare had not taken written positions with respect to whether pancreas transplants are experimental or investigational.

In response, Dr. Sutherland sent a letter dated October 27, 1990 to Eckerd requesting a formal appeal of Eckerd's decision to deny benefits regarding the pancreas transplant. Plaintiff's Exhibit 6. In this letter, Dr. sutherland provides significant additional information that undermines each of the bases given for the denial of Shannon's claim in the Azem letter of October 11, 1990. Dr. Sutherland writes that he did furnish Cost Care with data concerning survival rates at two and three years post-transplant and details the manner in which pancreas transplants affect improvements in the quality of life of diabetic patients. He also advises that, while Medicare had no written position regarding the [illegible]cal status of pancreas transplants, "Medicare has so uniform[illegible]overed renal transplant complications in pancreas recipients, [illegible]o deny the request for Mr. Shannon on this technicality indicates that the decision has been made on economic, and not on medical or quality of life issues". Finally, Dr. Sutherland cites statistical data supporting the position that the pancreas transplant procedure is well accepted and frequently performed.

The Plan Administrator's only response to Dr. Sutherland's letter was a letter dated December 10, 1990 to Lynn Shannon. The letter explained that Eckerd had received Dr. Sutherland's letter of October 27, 1990, that Eckerd was reviewing the information contained in the Sutherland letter, and that Eckerd would contact Shannon with a determination when the review was complete.

The Plan Administrator did not forward Dr. Sutherland's letter of October 27, 1990 to Cost Care for further review. Further, the Plan Administrator neither contacted Cost Care nor Dr. Sutherland at any time after receiving the October 27, 1990 letter to discuss any aspect of Shannon's claim, nor requested any further review by Cost Care or any other medical review organization. The Plan Administrator failed to take these steps even though she had earlier concluded that she was incapable of evaluating medical information regarding pancreas transplants and that a second consultation with a medial review organization was necessary. Although Dr. Sutherland's October 27, 1990 letter referred to Medicare's position regarding coverage for pancreas transplants, the Plan Administrator did not contact anyone at Medicare to inquire about Medicare's position concerning coverage of the procedure.

After receiving the letter, the plan Administrator did contact five insurance companies listed on an attachment to the Sutherland letter of September 7, 1990 and inquired whether these companies covered pancreas transplants. Four of these companies informed the Plan Administrator that they did not cover the procedure because they considered it to be "investigational". The Plan Administrator testified that she accepted the companies' definition of the term "investigational" without any inquiry as to the criteria used to determine that the pancreas transplant procedure met this definition. The day after the Plan Administrator sent her letter of December 10, 1992, she received a letter fax from Traveler's Insurance Co. ("Traveler's")--the fifth insurance company that she contacted. The fax sets out medical criteria governing a patient's suitability for a pancreas transplant. The Plan Administrator never contacted Traveler's to determine how the company used the information and never forwarded the information to Cost Care.

The Plan Administrator failed to inform either Shannon or Dr. Sutherland of her decision concerning Shannon's appeal[1]. The

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[1] This failure constitutes a violation of Plan section 8.3, which requires the Plan Administrator to communicate in writing his or her resolution of a claims appeal within sixty (60) days after receiving the document initiating the appeal.

Plan Administrator's ultimate decision to deny Shannon's claim occurred on December 28, 1990 by operation of law[2].

Following this denial, Shannon underwent a combined kidney/pancreas transplant operation in 1991. The kidney transplant was successful. Shannon's system, however, rejected the pancreas, necessitating a second pancreas transplant. To date, Shannon has not undergone the second pancreas transplant procedure. Shannon never communicated his need for second pancreas transplant to Eckerd except through this litigation.

The facts summarized above create the following issues:

I. Did Shannon properly file a claim within the meaning of the Plan with respect to either the combined kidney/pancreas procedure requested in 1990 or the second pancreas transplant procedure necessitated by the rejection of the first pancreas?

II. Did Shannon properly file an appeal of the denial of his claim for coverage of the combined kidney/pancreas transplant procedure?

III. Was the Plan Administrator's ultimate denial of Shannon's claim for coverage of the kidney/pancreas transplant procedure arbitrary and capricious?

CONCLUSIONS OF LAW

I. Filing

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[2] 29 C.F.R. 2560.503-1 provides that, absent special circumstances, if the decision on review of a denial of a claim has not been issued within sixty days after the date on which the document initiating review was filed, the claim shall be deemed denied on review. As noted earlier, Dr. Sutherland's letter of October 27, 1990 represents the document initiating review in the present case. As of December 27, 1990, the sixtieth day after the Sutherland letter was sent to Eckerd, Eckerd had not responded to the letter. Accordingly, Shannon's claim was deemed denied on review on December 28, 1990 pursuant to 29 C.F.R. 2560.503-1.

(i) Shannon filed a claim for coverage of a combined kidney/pancreas procedure

Shannon cannot recover benefits for the cost of a combined kidney/pancreas transplant unless he properly filed a claim for these benefits under the Plan. In order to determine whether Shannon properly filed a claim for these benefits, the Court must determine weather he had a standing to file a claim within the meaning of the Plan. Further, since Shannon communicated with Eckerd through Dr. Sutherland, the Court must determine whether Dr. Sutherland had standing to file a claim under the Plan on Shannon's behalf. Finally, the Court must determine whether Shannon's failure to file a claim form renders his claim invalid.

The Court finds that Shannon had standing to file a claim under the Plan. Section 8 of the Plan limits the availability of the claims procedure to "Participants" in the Plan. Plan section 2.26 defines "Participant" as, among other things, a "Dependent who is eligible for coverage and who is in fact covered for benefits under this Plan in accordance with Articles III and IV of this Plan Document". Pursuant to Plan section 2.6, the term "Dependent" includes the spouse of an Eckerd employee. It is not disputed that Shannon's wife was an Eckerd employee at all times material to this cause. Shannon was therefore a Dependent within the meaning of the Plan at all times material to this cause. In addition, at all times material to this cause, Shannon was eligible for coverage under Articles III and IV of the Plan and was in fact covered under those articles. Accordingly, the Court concludes Shannon satisfied all conditions necessary to qualify as a Participant under the Plan.

The Court also concludes that Dr. Sutherland had standing to file a claim on Shannon's behalf. Plan sections 8.2 and 8.3 require that the claims review and appeals procedures be initiated by a Participant. It cannot be reasonably disputed that physicians often assist their patients in the preparation of health insurance claims.[3] As

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[3] E. Haavi Morreim, Gaming the System: Dodging the Rules, Ruling the Dodgers, 151 Arch. Intern. Med. 443-447 (March, 1991) ("Today, the patient commonly, and necessarily, enlists the

this is a widespread practice, the Court finds that the term "Participant", as used in Plan sections 8.2 and 8.3, refers to both participants and physicians acting on their behalf.

At the very least, the regularity with which physicians act on behalf of their patients creates an ambiguity as to the scope of the term "Participant". This ambiguity, in conjunction with Eckerd's conduct, enables the Court to apply the doctrine of equitable estoppel to preclude Eckerd from denying that Dr. Sutherland had standing to file a claim on Shannon's behalf. Since ERISA preempts the application of state law with respect to the interpretation of ERISA-covered plans, the doctrine has its source in federal common law.

The doctrine contains three requirements. These requirements include: (1) an intentional deception through concealment or inaction, or gross negligence amounting to a constructive fraud, (2) justifiable reliance, and (3) damages. Zittrouer v. Uarco, Inc. Group Ben. Plan, 582 F.Supp. 1471 (N.D. Ga. 1984)[4].

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aid of his or her physician in preparing claims for health and disability. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information").

[4] The traditional formulation of the test concerning equitable estoppel requires the party asserting estoppel prove that the party against whom the doctrine is asserted misrepresented a material fact. See Nat'l Companies Health P., 929 F.2d at 1572. The Eleventh Circuit has held, however, that the formulation of the test articulated above is equivalent to the traditional formulation. In Nat'l Companies Health P., the court stated that:

> There are several different ways to recapitulate the elements of the federal common-law claim of equitable estoppel . . . . The Zittrouer test . . . is simply a reformulation of traditional estoppel principles, and is used for estoppel claims involving material omissions rather than misrepresentations; any difference between this test and the district court's (and our) test is

The Court finds that each of these elements is met here. There is no evidence that anyone at Eckerd ever informed either Dr. Sutherland or Shannon that Dr. Sutherland was not entitled to file a claim on Shannon's behalf. On the contrary, all of the communications made by Eckerd to Dr. Sutherland suggest that Eckerd treated the Sutherland letter of August 16, 1990 as a claim. Eckerd responded to the letter by telephonically advising Dr. Sutherland that the claim was denied. When Dr. Sutherland twice attempted to appeal the claim, Eckerd responded to the first attempt with a letter explaining the basis of its denial and to the second with a letter advising Dr. Sutherland that Eckerd was reviewing its denial. On the basis of this conduct, the Court finds that, if the term "participant" excludes a physician acting on a participant's behalf, then Eckerd either intentionally concealed this fact from Shannon or was grossly negligent in failing to inform him of this fact.

Moreover, it is clear that Shannon relied on his belief that Dr. Sutherland had standing to file a claim on his behalf. Shannon has taken an active interest in his medical condition for some time. The Court is convinced that, had Eckerd explained to either Shannon or Dr. Sutherland that Dr. Sutherland was not entitled to file a claim on Shannon's behalf, Shannon would have filed a claim personally. In view of the fact that physicians often assist plan participants with the filing of claims, the Court concludes that Shannon's reliance was justifiable. Finally, it is clear that Shannon would suffer damages if the Court were to decline to enforce coverage based on this reliance. As a consequence, all of the elements of equitable estoppel are met. Accordingly, the Court finds that Eckerd is estopped from denying that Dr. Sutherland's letter was sufficient to file a claim within the meaning of the Plan.

Finally, the Court finds that Shannon's failure to file a claim form does not invalidate his claim. Plan section 8.1 provides, among other things, that a claim form is required "for each Participant's separate Illness or Injury". According to Plan section 2.17, the term "Illness" refers to "sickness or disease which causes interruption,

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insignificant.
929 F.2d at 1572-1573.

cessation, or disorder of body functions, systems or organs, and which requires treatment by a Physician". Under this definition, Shannon's condition clearly constitutes an illness within the meaning of the Plan. It would therefore appear that Shannon was required to file a claim form in order to file a proper claim.

A close examination of the language in Plan section 8.2, however, belies this conclusion. Section 8.2 provides in pertinent part:

> Any Participant or former Participant, who wishes to request an informal review of a claim for benefits or who wishes an explanation of a benefit or its denial, must direct written request to the applicable Plan Administrator for an informal review. (Emphasis added).

The use of the underlined disjunctive indicates that an informal review of benefits is distinct from an explanation of a denial. The Court concludes that an "informal review of a claim for benefits" does not refer to a review of the denial of a claim, but rather refers to the initial review of the claim. There is no indication from the language of section 8.2 that a claim form is required to initiate such review. Rather, this review can only be initiated by the filing of a written request[5].

Even if Shannon had been required to file a claim form, the Court finds that Eckerd is estopped from asserting that Shannon's failure to file a claim form disqualifies his claim. Eckerd never informed either Dr. Sutherland or Shannon that a claim form was required to file a proper claim and at all times dealt with Dr. Sutherland as if Shannon had filed a proper claim. As a consequence,

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[5] Section 8.2 also provides, in subsection c, that the response issued pursuant to this request describes any material necessary to perfect the claim. This material would reasonably include a claim form if one had not been filed previously. The Court concludes that a claim form is not required in order to file a claim, merely to perfect a claim.

the Court finds that Eckerd either intentionally concealed the claim form requirement or negligently failed to apprise Shannon of the requirement. The Court also finds that Shannon relied on his belief that no such requirement existed and that Shannon would lose coverage if his failure to comply with the requirement were found to preclude coverage of the pancreas transplant procedure. Accordingly, Eckerd's conduct satisfies all of the elements of equitable estoppel.

Based on the foregoing, the Court finds that Shannon's failure to file a claim form does not invalidate his claim for benefits covering a combined kidney/pancreas transplant. The Court also finds that Dr. Sutherland's letter of August 16, 1990, which requests prior authorization for these benefits, represents the written request necessary to initiate a claim. The Court concludes that Shannon properly filed a claim for these benefits under the terms of the Plan.

(ii) Shannon did not file a claim for a second pancreas transplant.

The case law interpreting ERISA provides that a plan beneficiary or participant must exhaust his or her administrative remedies before ringing suit in federal district court pursuant to 29 U.S.C. § 1132(a)(1)(B). See, e.g. DePina v. General Dynamics, 674 F. Supp. 46 (D. Mass. 1987) (holding that requirement of exhaustion of administrative remedies applies to disputes involving ERISA plan benefits); see also, Amato v. Bernard, 618 F. 2d 559 (9th Cir. 1980). In the present case, however, there is no evidence in the trial record indicating that Shannon ever filed a claim for the pancreas transplant procedure necessitated by his body's rejection of the pancreas introduced in the combined kidney/pancreas transplant that he underwent in 1991. Accordingly, the Court finds that his suit to clarify the terms of the Plan and to enforce his alleged right benefits for a second pancreas transplant is premature.

II. Appeal

Under Plan section 8.3, Shannon properly filed an appeal of the denial of his claim for benefits covering a combined kidney/pancreas transplant

Plan section 8.3 permits a participant to appeal a claim for benefits that is wholly or partially denied. The section does not require that a claim be perfected in order to be appealable. Thus, the Court finds that Shannon's failure to file a claim form does not disqualify his appeal under this section. Even if a claim form were required, Eckerd's letter of December 10, 1990 indicates that Eckerd treated the Sutherland as an appeal. Accordingly, Eckerd is equitably estopped from asserting that Shannon's failure to file a claim form precluded appeal from the denial of his claim. See analysis supra.

III. Propriety of the Plan Administrator's Decision

The Plan Administrator's ultimate decision to deny Shannon benefits for a combined kidney/pancreas transplant was arbitrary and capricious.

The Plan Administrator's decision to deny benefits to Shannon is reviewable pursuant to the arbitrary and capricious standard of review. Under that standard, the Court must determine whether there was a reasonable basis for the Plan Administrator's decision. Jett v. Blue Cross and Blue Shield of Alabama, 890 F. 2d 1137, 1139 (11th Cir. 1989). In order to make that determination, the Court must make two findings. First, the Court must find that the Plan Administrator gathered facts sufficient to serve as the basis on which a reasonable decision might have been rendered. See Motor Vehicle Mfr. v. State Farm Mut., 103 S.Ct. 2856, 2866 (1983) (requiring that a decisionmaker subject to review under the arbitrary and capricious standard "examine the relevant data and articulate a satisfactory explanation for its actions"); Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 (9th Cir. 1990) (upholding district court's finding that evidence gathered by an ERISA administrator provided an altogether inadequate basis for administrator's denial of benefits under group health and medical policy and therefore that denial was arbitrary and capricious). Second, the Court must find that the Plan Administrator rendered a reasonable decision after these facts. See Jett, 890 F. 2d at 1139.

The Plan Administrator's decision was based on Plan section 5.8(t)(i), which became effective on June 1, 1990 and which defined the Plan's coverage with respect to organ transplants. The section

provided that:

> (t) Charges associated with organ transplants will be covered as follows:
>
> (i) The Plan will pay the regular portion of medically necessary reasonable and customary hospital and medical expenses related to the transplant of medically recognized human organ or tissue transplants from a cadaver donor to a transplant recipient.
>
> Transplants that are experimental/ investigative as determined by the Plan Administrator are not covered.

The Plan contained no definition of these terms "experimental" or "investigative". The conduct of the Plan Administrator between August 16, 1990--the date on which Shannon's claim was first filed--and December 27, 1990--the date on which Shannon's claim was ultimately denied--is relevant to the reasonableness of the Plan Administrator's decision.

The Court finds that the Plan Administrator's failure to inform Shannon of her ultimate decision regarding the appeal of his claim was not arbitrary and capricious. See Newell v. Prudential Ins. Co. Of America, 725 F. Supp. 1233, 1239 (N.D. Ga. 1989) (holding that the failure of an administrator of employee welfare benefit plan and/or its preadmission and concurrent review service to meet its self-imposed standard for affording oral and written notice to hospital, patient, and physician concerning precertified authorization was not arbitrary or capricious).

The Court also finds, however, that the Plan Administrator failed to gather facts sufficient to establish a reasonable basis for denying Shannon's claim. The Plan Administrator testified that she based her ultimate decision to deny Shannon's claim on the following three criteria: (i) the fact that Medicare denied payment for Shannon's claim, (ii) the fact that Cost Care advised her that the pancreas

transplant procedure was regarded as investigational by the medical community, and (iii) the fact that a number of insurance companies classified the procedure as investigational.

The Plan Administrator, however, failed to adequately investigate any of these criteria. Although the Plan Administrator claims to have known that Medicare denied Shannon's claim, there is no evidence that she was aware of the basis for this denial. Medicare might have denied the claim based on criteria unrelated to whether the procedure was investigational. Medicare, for instance, might have declined coverage for pancreas transplants for economic reasons. If this had been the case, Medicare's decision to deny Shannon benefits would have no bearing on whether the pancreas transplant procedure is investigational. In addition, the Plan Administrator knew that Medicare had no formal position in writing concerning whether the procedure was experimental or investigational and learned from Dr. Sutherland that Medicare had often covered procedures related to renal transplant complications in the past. Under these circumstances, the Plan Administrator's failure to make further inquiry into Medicare's position on the status of the pancreas transplant procedure renders any reliance on the fact that Medicare denied Shannon's claim unreasonable.

The Plan Administrator also failed to adequately investigate the medical status of the pancreas transplant procedure. After receiving Dr. Sutherland's letter of October 27, 1990, the Plan Administrator had notice that Cost Care's conclusion that the procedure was investigational may have been made without all of the data relevant to survival rates post-transplant and without any consideration for quality of life improvements associated with the procedure. Despite this notice, the Plan Administrator did nothing to ensure a more thorough evaluation. The Plan Administrator did not engage another medical consultant for a second evaluation, despite her conclusion that a second evaluation was necessary. She did not contact Dr. Sutherland--one of the country's leading authorities on the procedure and Shannon's treating physician--for further explanation of his criticisms of Cost Care's evaluation. She did not request that Cost Care review its conclusion nor demand that Cost Care issue a more complete explanation of the basis for its conclusion. In fact, the Plan Administrator did not even contact Cost Care to apprise Cost

Care of the new information that she had received. The Plan Administrator failed to take any of these actions despite her admitted inability to comprehend either the substance or significance of information related to the medical status of the pancreas transplant procedure. The Court concludes that the Plan Administrator simply ignored the information the Sutherland letter of October 27, 1990 criticizing Cost Care's evaluation. Under these circumstances, the Court finds that any reliance that the Plan Administrator placed on Cost Care's evaluation was unreasonable. See White v. Caterpillar, 765 F. Supp. 1418 (W.D. Mo. 1991) (holding that the termination by the administrator of an ERISA plan that autologous bone marrow transplantation procedure was an "investigational" treatment was arbitrary and capricious in light of a recent study which should have put the administrator on notice that the efficacy of the procedure was at least debatable, so that further examination would have been prudent).

The only other basis for the Plan Administrator's decision was that four out of the five insurance companies that she contacted classified the pancreas transplant procedure as investigational. The Court concedes that the Plan Administrator might have based her interpretation of the term "investigational" on a consensus within the insurance industry as to the meaning of the term. The Court finds, however, that the Plan Administrator's investigation was insufficient to determine whether such a consensus existed. The Plan Administrator had Dr. Sutherland's list of more than fifty insurance companies which had, in Dr. Sutherland's experience, covered the pancreas transplant procedure. She made no independent effort to determine how many other insurance companies had taken positions with respect to coverage for pancreas transplants or to determine what number of insurance companies would have furnished a reliable representation of the industry's view on the subject. Instead, she contacted only five of the companies on Dr. Sutherland's list and never inquired as to the manner in which any of these companies defined the term "investigational". Although four out of the five companies that she contacted classified the pancreas transplant procedure as "investigational", the criteria that these insurers used to make this classification may have been radically different. The insurers may thus have reached very different conclusions about the procedure. As a consequence, the fact that four insurers

characterized the procedure as "investigational" was insufficient to reveal any real consensus as to the meaning of that term within the industry.

CONCLUSION

Based on the foregoing findings of fact and conclusions of law, the Court concludes that, under the terms of the Plan, Shannon properly filed a claim for a combined kidney/pancreas transplant and properly took an appeal from the denial of that claim. The Court further concludes that the Plan Administrator's decision to deny benefits for this claim was arbitrary and capricious. This conclusion, however, does not authorize the Court to award Shannon benefits for the combined kidney/pancreas transplant that he underwent in 1991. Where the Court determines that a plan administrator's decision concerning a benefits claim was arbitrary and capricious because the plan administrator failed together sufficient evidence upon which a reasonable decision might have been based, the Court must remand the matter to the plan administrator for a new determination. Jett, 890 F. 2d at 1140 ("'As a general matter a court should not resolve the eligibility question on the basis of evidence never presented to [an ERISA plan's administrator] but should remand to the [administrator] for a new determination'") quoting Wardle v. Central States, Southeast and Southwest Areas Pension Funds, 627 F. 2d 820, 824 (7th Cir. 1980); Berry v. Ciba-Geigy Corp., 761 F.2d 1003 (4th Cir. 1985) ("If the court believed the administrator lacked adequate evidence, the proper course was to 'remand to the trustees for a new determination' . . . "). The Plan Administrator's failure to consider all of the relevant evidence available at the time she made her determination renders that determination arbitrary and capricious. As a consequence, the Court must remand the matter to the Plan Administrator for a new determination.[6]

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[6] The Court notes that the Plan Administrator's new determination must be made after a reasonable inquiry into all relevant evidence available up to the date of the new determination. See Bucci v. Blue Cross-Blue Shield of Conn., 764 F. Supp. 728 (D. Conn. 1991) ("[D]efendant's duty to provide benefits is a continuing one, its refusal to provide benefits is thus a continuing

In the Amended Complaint, Shannon also sought to "clarify his right" to future benefits covering a second pancreas transplant. Shannon, however, did not present any evidence that he filed a claim with Eckerd for benefits covering a second pancreas transplant or for other "future benefits". As a consequence, Shannon has not exhausted his administrative remedies under the Plan concerning his request for a declaration of his right to future benefits and the Court cannot therefore grant such relief at this time.

DONE AND ORDERED in chambers, Miami, Florida, this 18th day of November, 1992.

LENORE C. NESBITT
UNITED STATES
DISTRICT JUDGE

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denial, the propriety of which is measured against the information available from time to time.").

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff,

v.

JACK ECKERD CORPORATION,

Defendant

FINAL JUDGMENT

For the reasons stated in the Order Granting Plaintiff's Motion for Entry of Final Judgment entered on the date hereof, it is thereupon

ORDERED AND ADJUDGED that the judgment be entered in favor of Plaintiff Thomas Shannon and against Defendant Jack Eckerd Corporation in the amount of $70,714.35 plus pre-judgment interest, costs, and attorney's fees.

DONE AND ORDERED in Chambers at Miami, Florida, this 31st day of October, 1995.

LENORE NESBITT
U.S. DISTRICT JUDGE

Thomas SHANNON, Plaintiff-Appellee,

v.

JACK ECKERD CORPORATION, a
Delaware Corporation, Defendant-
Third Party Plaintiff-Appellant,

Cost Care, Inc., a California Corporation,
Third-Party Defendant.

No. 96-4291

United States Court of Appeals,
Eleventh Circuit

May 29, 1997

Employee insured under Employee Retirement Income Security Act (ERISA) plan filed action against plan administrator, alleging that administrator acted arbitrarily and capriciously in denying him coverage for pancreas transplant. The United States District Court for the Southern District of Florida, No. 910271-CIV-LCN, Lenore Carrero Nesbitt, J., remanded matter to administrator. Administrator appealed. The Court of Appeals, 55 F.3d 561, dismissed appeal. On remand, plan administrator determined that pancreas operation was covered under current standards, but refused to pay any benefits on basis that procedure was investigational at time claim was made. The District Court, No. 91-0271-CIV-NESBITT, entered final judgment for amount of benefits. Administrator appealed. The Court of Appeals, Barkett, Circuit Judge, held that district court did not err in directing plan administrator to consider all relevant evidence on remand, and under that standard propriety of denial was to be measured against information available at time of reconsideration.

Affirmed.

Appeal from the United States District Court for the Southern District

of Florida.

Before HATCHETT, Chief Judge, BARKETT, Circuit Judge, and RONEY, Senior Circuit Judge:

Thomas Shannon filed this action after Jack Eckerd Corporation denied his request for preauthorization of benefits under an employee group health plan. Eckerd is appealing the district court's judgment awarding Shannon $70,714.35. Eckerd argues on appeal that the district court erred in denying its motion for summary judgment and in finding that the Plan's original denial of benefits was arbitrary and capricious. Eckerd also contends that the district court erred in directing the Plan administrator on remand to consider evidence available subsequent to the denial determination.

Thomas Shannon is a beneficiary under the Jack Eckerd Corporation Health Benefits Plan ("the Plan"), a self-funded plan governed by the Employee Retirement Income Security Act ("ERISA"). Shannon suffers from long-term diabetes mellitus Type I, which has resulted in severe renal disease and kidney failure. Due to these complications, Shannon's doctor advised Shannon to undergo a kidney transplant. After further consultation with other physicians, Shannon decided to undergo a simultaneous kidney/pancreas transplant at the University of Minnesota. The University of Minnesota requires either advance payment or verification of insurance coverage before a patient can be placed on the cadaveric pancreas transplant list. Accordingly, Shannon's surgeon requested preauthorization of benefits for the procedure from the Plan. At the time Shannon sought benefits for his transplant, the Plan excluded coverage for experimental or investigational human organ transplants. The Plan administrator rejected the claim for those benefits, informing Shannon and his surgeon that although the Plan would cover expenses associated with the kidney transplant, it could not cover expenses associated with the pancreas transplant because it was medically experimental or investigational and the Plan excluded coverage for experimental or investigational human organ transplants. Shannon's surgeon filed a formal appeal but the Plan administrator continued to deny coverage for the pancreas portion of the transplant. Shannon went forward with the transplant using other funding, but the pancreas graft failed. Shannon then sued under

ERISA, 29 U.S.C. § 1132(a)(1)(B)[7] to recover the benefits denied by the Plan administrator. After a bench trial, the district court found that in rejecting the claim as investigational, the Plan administrator had failed to consider all of the relevant evidence available and concluded that this failure rendered the Plan administrator's denial of benefits for the pancreas portion of the transplant arbitrary and capricious. The district court remanded the matter to the Plan administrator for a new determination based upon all relevant evidence including subsequently available evidence.[8] On remand, the Plan administrator determined that the pancreas operation was covered under current standards. However, the Plan refused to pay Shannon any benefits, arguing that at the time Shannon made his claim the procedure was experimental/investigational. Shannon again sought relief in the district court and the district court entered final judgment for the benefits in accordance with the Plan administrator's conclusion that the pancreas procedure was covered.

[1-3] We review a district court's grant of summary judgment *de novo* applying the same legal standards that control the district court's determination. *Jones v. Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed 80 (1989); *Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1138-1139 (11th Cir. 1989); There is no dispute that the Eckerd Plan gives its administrator discretionary authority to determine eligibility for benefits. Therefore, we must determine whether the Plan administrator's decision was arbitrary and capricious. *Jett*, 890 F.2d at 1139. A decision to deny benefits is arbitrary and capricious if no reasonable basis exists for the decision. *Id.* In this case the district court found that in evaluating whether the proposed procedure was

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[7] "A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C.A. § 1132(a)(1)(B) (West 1985).

[8] Eckerd's appeal to this Court of the remand order was dismissed for want of jurisdiction.

experimental or investigational, the Plan administrator relied only on Medicare's denial of coverage, a conclusory recommendation of denial from Cost Care, the Plan's medical consultant, and the statements of several insurance companies that pancreas transplants were "investigational". The court concluded that this was an insufficient basis to support the denial. Simply accepting the bald assertion of Cost Care and the denial of other insurance companies without examining or evaluating their underlying bases and falling to obtain additional relevant information was arbitrary and capricious. We cannot say that the district court erred in remanding for the Plan administrator to make a reasonably relevant inquiry.

[4] Nor can we say that the district court erred in directing the Plan administrator to consider subsequently available evidence. The district court relied on *Buddi v. Blue Cross-Blue Shield of Conn.*, 764 F.Supp. 728, 732 (D.Conn. 1991), holding that since a defendant's duty to provide benefits "is a continuing one, its refusal to provide benefits is thus a continuing denial, the propriety of which is measured against the information available from time to time." Eckerd's Plan administrator had an obligation to make a reasonably relevant inquiry and failed to do so at the time of the original determination. The district court did not err in directing that the Plan administrator consider all available evidence. As we stated in *Jett*, "Should [the beneficiary] wish to present additional information that might affect the determination of eligibility for benefits, the proper course would be to remand to [the plan administrator] for a new determination." 890 F.2d at 1140. Accordingly, we AFFIRM.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff-Appellee,

v.

JACK ECKERD CORPORATION,
a Delaware corporation,

Defendant-Third Party
Plaintiff-Appellant,

COST CARE, INC., a
California corporation,

Third Party Defendant.

On Appeal from the United States District Court
for the Southern District of Florida

ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING EN BANC

Before: HATCHETT, Chief Judge, BARKETT, Circuit Judge, and RONEY, Senior Circuit Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

jack eckerd corporation

August 31, 1993

Mr. Thomas Shannon

Dear Mr. Shannon:

This is a redetermination of your claim for a combined pancreas/kidney transplant made on August 16, 1990 pursuant to the Jack Eckerd Corporation Employee Health Benefits Plan. As you are aware, the Plan has always maintained that the renal portion of the procedure was a covered expense, but that the pancreas portion of the procedure was not a covered expense because it was considered to be an investigational procedure. The Plan stands by their original determination, and has made this redetermination only because it has been ordered to do so by the United States District Court for the Southern District of Florida in Case No. 91-0271-CIV- Nesbitt/Bandstra. It is further to be noted that the matter is currently on appeal before the United States Court of Appeals for the Eleventh Circuit, and that the Plan reserves all appellate rights. Therefore, this redetermination is not to be considered in any fashion as a waiver of the Plan's appellate rights.

In addition, in accordance with the Court's order, the Plan has made its redetermination based on current information and standards. Again, the Plan does not concede that current standards apply, and in fact maintains that this is an issue to be decided by the United States Court of Appeals for the Eleventh Circuit. Therefore, the fact the Plan made the redetermination contained herein in accordance with current standards is not to be construed as a waiver of any of its appellate rights.

It must first be noted that neither you nor Dr. Thomas Sutherland, your treating physician and the person most active in pursuing this claim on your behalf, submitted any additional information to the Plan to be considered. Accordingly, the Plan undertook its own research to make the redetermination in accordance with the Court's order.

The Plan's utilization review physician who acts as consultant to the Plan is of the belief that, <u>under current standards</u> a pancreas transplant is no longer considered experimental or investigational. Therefore, the currently available clinical data suggests that, at least in the medical sense, this procedure is no longer considered to be investigational.

BEST AVAILABLE COPY

Medicare, your primary health insurer, still will not cover pancreatic transplant because it considers the procedure to be investigational and/or experimental. However, Medicaid of Florida does cover the procedure. Of the insurance companies which we were able to contact, approximately 80%, under current standards, consider the procedure to be non-experimental and/or non-investigational, and of those insurers which do not specifically exclude pancreatic transplant will cover the procedure. Significantly, the companies which now consider, under current standards, the procedure to be covered include Aetna, John Hancock, and Prudential, all of which refused to cover the procedure at the time your claim was first made, on the grounds that it was experimental or investigational.

In light of the foregoing, the Plan has concluded that, under current standards, the pancreas transplant is currently considered neither experimental nor investigational, and would be covered under Article V, Section 5.8(t) of the Plan document amendments effective June 1, 1990, which governed your claim.

Respectfully,

(Deloris Nelms)

Deloris Nelms
Manager, Health Claims

(2)

Supreme Court, U.S.
FILED
JAN 8 1998
CLERK

No. 97-948

In The

Supreme Court of the United States

October Term, 1997

JACK ECKERD CORPORATION,

Petitioner,

vs.

THOMAS SHANNON,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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57 pp

QUESTION PRESENTED

The respondent respectfully restates the "Question Presented" so as to have it more accurately reflect the precise issue before the Court under the terms and circumstances of this case (*see* Supreme Court Rules, Rule 15, paragraph 2):

A.

WHETHER THE OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT (1) IS IN DIRECT CONFLICT WITH ANY APPLICABLE DECISION OF EITHER THIS COURT OR OF ANY FEDERAL COURT OF APPEALS AS TO ANY ISSUE HEREIN DECIDED, OR (2) DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT YET BEEN SETTLED, BUT SHOULD BE SETTLED, BY THIS COURT.

PARTIES/INTRODUCTION

The respondent, Thomas Shannon, was the plaintiff in the trial court and was the appellee in the Eleventh Circuit Court of Appeals. The petitioner, Jack Eckerd Corporation, was the defendant/appellant. In this brief of respondent in opposition to the petition for writ of certiorari the parties will be referred to as the petitioner and the respondent and, alternatively, by name. The references "Pet. App." and "Resp. App." will refer to the petitioner's appendix and the appendix accompanying this brief, respectively. All emphasis has been supplied by counsel unless indicated to the contrary.

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APPENDIX

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Appendix B — Order Of The United States District Court for the Southern District Of Florida Filed March 22, 1993 ..... 27a

Appendix C — Order Of Remand of The United States District Court Southern District Of Florida Filed November 16, 1992 ..... 33a

STATEMENT OF THE CASE

A. History of the Proceedings

At the outset, with due regard for what the petitioner has recited in its "Statement" and with further recognition for the contentions and arguments advanced in that portion of the petition denominated "Reasons For Granting The Petition," respondent suggests that neither the issues petitioner advances nor the basis upon which the lower courts premised their rulings and/or decisions should be viewed in the abstract. As the Court of Appeals stated in affirming the trial court's judgment:

> . . . We must determine whether the Plan Administrator's decision was arbitrary and capricious (citation omitted). A decision to deny benefits is arbitrary and capricious if no reasonable basis exists for the decision. Id. In this case the District Court found that in evaluating whether the proposed procedure was experimental or investigational, the Plan Administrator relied only on Medicare's denial of coverage, a conclusory recommendation of denial from Cost Care, the plan's medical consultant, and the statements of several insurance companies that pancreas transplants were "investigational". *The court concluded that this was an insufficient basis to support the denial.* Simply accepting the bald assertion of Cost Care and the denial of other insurance companies *without examining or evaluating their underlying bases* and *failing to obtain additional relevant information* was arbitrary and capricious. We cannot say that the District Court erred in remanding for the Plan Administrator to make a reasonably relevant inquiry.

> Nor can we say that the District Court erred in directing the Plan Administrator to consider subsequently available evidence. The District Court relied on Bucci v. Blue Cross-Blue Shield of Conn., 764 F. Supp. 728, 732 (D. Conn. 1991), holding that since a defendant's duty to provide benefits "is a continuing one, its refusal to provide benefits is thus a continuing denial, the propriety of which is measured against the information available from time to time." Eckerd's Plan Administrator had an obligation to make a reasonably relevant inquiry and failed to do so at the time of the original determination. The District Court did not err in considering that the Plan Administrator consider *all* available evidence (citation omitted).

(Pet. App. 20, 21).

B. "The Plan Administrator"

Micki Keener is the manager of employee benefits of the petitioner and *is* its plan administrator (Resp. App. 1a-4a). She has no medical background. The petitioner employed no physicians trained in the field of transplant medicine. The respondent provided Keener's first experience with transplants (Resp. App. 5a-7a).

At all times pertinent it was undisputed that the subject plan would not cover transplants deemed "experimental" or "investigational." The subject plan gives discretion to the plan administrator to decide what is "experimental" and/or "investigational" (Resp. App. 22a-23a). What the plan *did not give* was a definition for either term. Keener herself had no knowledge of the medical definition of the words (Resp. App. 7a-8a).

Under the plan, as amended, Keener had the duty to determine whether or not benefits (transplants) were covered.

In this vein, and consistent with reasonable protocol, consultants were hired to give advice (Resp. App. 11a-14a). In this case the consultant was Cost Care, Inc. (Resp. App. 14a).

Keener had her own "working definition" for the two subject phrases (Resp. App. 23a-24a). She did not get them from any dictionary (Resp. App. 23a-24a). She made no effort to determine if anyone else agreed with her definitions (Resp. App. 23a-24a):

> I didn't need anything more than my working definition.

(Resp. App. 23a).

Keener did not compare her working definition with anyone else's (Resp. App. 23a-24a). Keener candidly admitted she never spoke to anyone at Cost Care about the predicate for the opinions rendered as a consequence of the letter of September 7, 1990. Keener stated:

> a. I would not question their medical opinions.

(Resp. App. 10a); and

> b. *She did not think it would have been appropriate for her* to call Cost Care *to ask who they inquired of*, who or what they read in formulating the opinions, etc.

(Resp. App. 10a-14a).

Post (initial) denial, and upon statutorily authorized and plan mandated review, Keener was given more information from Dr. Sutherland. *Most, if not all, of what she was given established that the requested transplant was neither experimental nor investigational.* In this regard the trial court noted:

> After receiving Dr. Sutherland's letter of October 27, 1990, the Plan Administrator had notice that Cost Care's conclusion that the procedure was investigational may have been made without all of the data relevant to survival rates post-transplant and without any consideration for quality of life improvements associated with the procedure. Despite this notice, the Plan Administrator did nothing to ensure a more thorough evaluation. The Plan Administrator did not engage another medical consultant for a second evaluation, despite her conclusion that a second evaluation was necessary. She did not contact Dr. Sutherland — one of the country's leading authorities on the procedure and Shannon's treating physician — for further explanation of his criticisms of Cost Care's evaluation. She did not request that Cost Care review its conclusion nor demand that Cost Care issue a more complete explanation of the basis for its conclusion. In fact, the Plan Administrator did not even *contact* Cost Care to apprise Cost Care of the new information that she had received. The Plan Administrator failed to take any of these actions despite her admitted inability to comprehend either the substance or significance of information related to the medical status of the pancreas transplant procedure. The Court concludes that the Plan Administrator simply ignored the information the Sutherland letter of October 27, 1990 criticizing Cost Care's evaluation.

(Pet. App. 13, 14).

Keener testified she contacted a limited number of insurance companies to ask about transplants and whether same were

covered. Keener never requested the persons who she contacted at any of the insurance companies to send to her a copy of *their plans* to review nor did she ask "why." Hence, Keener really did not know *why* those companies *denied* transplant benefits (Pet. App. 13, 14; Resp. App. 15a).

Likewise, Keener never contacted any pancreas transplantation performing physicians (anywhere) to ask *them* if they considered the procedure to be experimental or investigative (Resp. App. 20a-21a).

The plan (as "ERISA" requires) provided for review of a denial of benefits (Resp. App. 17a). Keener admitted that even if it came to her attention that some error was made in Cost Care's methodology of determining the claim, she could not say whether any other actions would have been taken (by her) (Resp. App. 18a-19a). In point of fact *Keener admitted that even upon review no matter what may have been advanced (by the appealing claimant) all she wanted was Cost Care's bottom line*! (Resp. App. 20a).

C. "A Proper Perspective"

Given the above, this Court can clearly see that what the petitioner now complains of, evolved *not because* the trial court ruled that the Plan Administrator was "incorrect" in her ultimate decision, but, rather, because the Plan Administrator simply accepted:

> . . . the bald assertion of Cost Care and the denial of other insurance companies without examining or evaluating their underlying bases and failing to obtain additional relevant information . . .

(Pet. App. 21).

Absent from the subject petition is any reference to the trial courts order *denying* the petitioner's motion for new trial

(Resp. App. 27a-32a). In that order the trial court highlighted the flaws in the petitioner's analysis:

> This cause comes before the Court upon Defendant Jack Eckerd Corporation's ("Eckerd") Motion for a New Trial. After due consideration, Eckerd's motion is DENIED. While the contentions Eckerd advances were addressed in the Court's Findings of Fact and Conclusions of Law, issued November 18, 1992. The present order seeks to clarify any ambiguity that may have been raised by the Order of November 18, 1992.
>
> * * *
>
> In support of its determination that the Plan Administrator failed to adequately investigate the medical status of the pancreas transplant procedure, the Court found that the October 27, 1990 from Dr. Thomas Sutherland — Shannon's treating physician — to the Plan Administrator constituted notice to the Plan Administrator that Cost Care's conclusion that the procedure was investigational may not have been well founded. Eckerd contends that the information referenced in the letter had already been transmitted to Cost Care by the time the Plan Administrator received the letter and that the Plan Administrator was aware of this transmission. Even if this contention is correct, it is irrelevant. *The fact that one of the nation's leading authorities on pancreas transplants raised significant objections to Cost Care's conclusion should have induced the Plan Administrator to either question Cost Care as to the basis for its conclusion or to engage a second medical consultant for another evaluation. The Plan Administrator did neither.*

* * *

Eckerd also objects to the Court's requirement that, in making a new determination on remand, the Plan Administrator consider all relevant evidence available up to the date of the new determination. All of the relevant decisional authority on point is consistent with this proposition. In *Jett v. Blue Cross and Blue Shield of Alabama*, 890 F. 2d 1137 (11th Cir. 1989), for instance, the Eleventh Circuit quoted a Seventh Circuit decision for the proposition that:

> As a general matter a court should not resolve the eligibility question on the basis of evidence never presented (to an ERISA plan's administrator) but should remand to the (administrator) for a new determination.

This language clearly prohibits the *district court* from considering evidence not presented to an ERISA plan administrator when reviewing the administrator's decision under the arbitrary and capricious standard. To allow the district Court to consider such evidence would convert review under the arbitrary and capricious standard into *de novo* review.[2] Nothing in the quoted language, however, suggests that a plan administrator to is not obligated to consider this evidence. To the contrary, the purpose of remand is to provide the plan administrator with the opportunity to consider the evidence.

---

2. All of the cases cited by Eckerd simply preclude the *district court*, not the plan administrator, from considering new evidence.

(Resp. App. 30a).

Berry v. Ciba-Geigy Corp., 761 F. 2d 1003 (4th Cir. 1985) provides the clearest expression of this position. In *Berry*, a case cited with approval by both the Eleventh Circuit and Eckerd, the Fourth Circuit explained that:

> While it is open to the trial judge to consider whether ... (the plan administrator) erred in not securing sufficient evidence on which to base a termination decision, it was error for the court to admit into evidence ... after the fact testimony ... If the court believed the administrator lacked adequate evidence, the proper course was to "remand to the trustees for a new determination." ...

Clearly, if the plan administrator failed to gather sufficient evidence in the course of rendering the first decision, the plan administrator cannot rely exclusively on that evidence in rendering the decision on remand. Rather, the plan administrator must gather enough additional evidence as is necessary to ground a reasonable decision. Moreover, on remand, the plan administrator is obligated to make a *new* determination — i.e., to make a determination as though no prior determination had been made. As a consequence, the plan administrator is obligated to consult all relevant evidence available up to the date of the new determination. Requiring the plan administrator to consult such evidence does not affect the plan administrator's discretion in rendering the decision on remand, it merely requires that the decision be reasonable in light of all the facts presently available.

The respondent reserves the right to argue the significance of the above facts in the argument portion of this brief.

REASONS FOR DENYING THE WRIT

THE OPINION OF THE ELEVENTH CIRCUIT HEREIN SOUGHT TO BE REVIEWED: (1) IS NOT IN CONFLICT, DIRECT, INDIRECT, EXPRESS OR IMPLIED WITH THE TWO DECISIONS OF THE EIGHTH CIRCUIT RELIED UPON; AND (2) DID NOT DECIDE ANY IMPORTANT QUESTION OF FEDERAL LAW SUCH THAT THIS COURT SHOULD EXERCISE ITS DISCRETION AND REVIEW THE MERITS OF THIS CASE.

The petitioner contends, at page 6 of its petition:

> Even assuming *arguendo* that the 11th Circuit was correct in affirming the District Court's finding that the plan acted arbitrarily and capriciously in denying respondent Shannon benefits for the pancreas transplant and remanding the matter to the petitioner plan for reconsideration, the appellate court nevertheless erred in affirming the District Court's directions to the plan to consider on remand evidence available after the date of the plan's original coverage decision. *The 11th Circuit's decision is squarely in conflict with the decisional law of the Eighth Circuit, notably the decisions in Bernards v. United of Omaha Life Insurance Co.*, 987 F. 2d 486 (1993) *and Cox v. Mid-America Dairymen, Inc.*, 965 F. 2d 569 (Eighth Cir. 1992) . . .

The respondent would suggest to this Court the opinion herein sought to be reviewed is not in conflict with either one of the two opinions relied upon. As there exists no conflict between

decisions, respondent requests this Court to exercise its discretion and *deny* merits review.

Cox v. Mid-America Dairymen, Inc., 965 F.2d 569 (8th Cir. 1992), a two-one decision by a panel of the Eighth Circuit, involved an appeal from an order of the trial court which *granted summary judgment* to the employee. In reversing the judgment appealed the Court, after stating the facts, concluded:

> We have previously noted that, in order to properly apply the differential standard of review, a reviewing court must be provided the rationale underlying the trustee's discretionary decision (citation omitted). On this record, we conclude that the retirement committee has failed to provide a sufficient explanation of its rationale, in light of the plan provisions that it was applying, *to permit us to review* its decision under the appropriate differential standard of review. As we noted (citation omitted) reviewing courts should avoid unduly complicating the task of plan trustees with unnecessary formal requirements. But when critical terms of the plan are ambiguous and conflicting medical evidence could arguably support a decision either way, we believe that Congress in ERISA, as well as traditional trust law principles . . . require that ERISA trustees *adequately explain the basis for their discretionary decisions.*
>
> Accordingly, we reverse the District Court's award of benefits and attorney's fees in favor of Cox. The case is remanded to the District Court with directions to remand to the retirement committee for reconsideration of Cox' application for disability benefits . . .

965 F.2d at 574. The opinion, as herein relevant, stands for the proposition that where the administrator fails to provide the

rationale underlying his (her or its) discretionary decision so that the reviewing court is *unable* to determine, "under the appropriate differential standard of review," 965 F.2d at 574, whether the trustee adhered to the plan's term, etc. reversal and remand is appropriate. However, in *Cox* the appellate court had before it *neither* the issue of what evidence the plan administrator should consider on remand *nor* the issue of whether the plan administrator abused its discretion! The court dealt only with the threshold issue of whether the plan administrator adequately explained:

> . . . the basis for their discretionary decisions . . .

965 F.2d at 574. Such is *not* the instant cause! As has already been pointed out in the respondent's "Statement of the Case," the trial court determined here that the Plan Administrator acted arbitrarily and/or capriciously in ignoring much of the information that was available to her. *Cox, supra*, is both factually and legally distinguishable from the instant cause.

Likewise, the petitioner's reliance upon *Bernards v. United of Omaha Life Insurance Company*, 987 F.2d 486 (1993), is equally misplaced.

Bernards, like *Cox*, involved an appeal by the company from an order granting *summary judgment* in favor of the insured. In *Bernards*, like *Cox*, the appellate court reversed *because*:

> . . . We now conclude that the record before the District Court was *insufficient* to finally determine *whether* United's denial of benefits was arbitrary and capricious or an abuse of discretion.

987 F.2d at 487. However, in *Bernards*, ***unlike Cox***, because the factual situation involved the rapidly deteriorating health of the insured, the appellate court noted:

> . . . This case is more complicated, however, because the emergency situation has caused the parties to bypass the binding arbitration procedure provided in the plan and to seek immediate judicial review. To conduct meaningful review in *these* circumstances, the District Court must obtain from United a further explanation of its decision, afford Bernards the opportunity to present evidence challenging the decision (he surely would have presented evidence had he appealed the decision to an arbitration panel), and then apply the differential standard of review to the expanding record . . .

987 F.2d at 489.

The instant cause presents no situation "analogous to" either *Cox* or *Bernards*. On page 7 of the petition it is argued:

> In neither Cox nor Bernards was the ERISA plan directed to consider evidence which may have developed in a lengthy period of time between the time of the participant or beneficiary's benefits claim and a time of remand. Rather, the Eighth Circuit's decisions make it clear that the remand is only for the purpose of the plan being able to better explain and, if need be, to reconsider the evidence that it had before it at the time it made its original decision.

With all due respect to the petitioner's right to *advance* an argument, the petitioner has gotten off track.

First, the Eighth Circuit has *not* "addressed this issue." All that occurred in each one of the two cited authorities was a reversal of a *summary final judgment* because "explanation" for the initial determination regarding benefits was lacking. The

issue advanced herein by the petitioner was never reached, much less advanced, addressed or identified in either *Cox* or *Bernards*!

Second, save for the two Eighth Circuit cases cited by the petitioner as support for the proposition it advances to this Court, there does not seem to be *any* citation by the petitioner to any other cases "on the issue" at all, much less to support a conclusion that:

> The Eighth Circuit's approach is the correct one and represents the majority view of courts which have had occasion to reach this issue . . .

Petition at 7. Respondent does not disagree with the principles of law found in the cases cited by petitioner which generally recognize that medical science is a dynamic process and, what may be experimental today may be accepted therapy tomorrow. *See* petition at 7. The respondent, however, does not believe that *the existence of* such principles requires the result petitioner is struggling to reach. It is for precisely this very reason why the result here does not "conflict with," "run afoul of," or "do injustice to," the cases otherwise cited at page 8 of the petition, exemplified by the case of *Sheppard & Enoch Pratt Hosp. Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 125 (4th Cir. 1994) which the petitioner extensively quotes:

> We continue to adhere to the view expressed in Berry that an assessment of the reasonableness of the administrator's decision must be based on the facts known to it at the time. Thus, *although it may be appropriate for a court conducting the de novo review of a plan administrator's action to consider evidence that was not taken into account by the administrator, the contrary approach should be followed when conducting a review under either an*

> *arbitrary and capricious standard* or under the abuse of discretion standard.

See Petition at 8. The instant cause does not collide with *Sheppard* or the other cases cited at page 8 of the petition. In *Sheppard* the court noted that where review obtains under either an arbitrary and capricious standard or under the abuse of discretion standard, a District Court *cannot consider anything* that the plan administrator *did not have available to it at the time of the initial determination*! This is consistent with those principles of law now well established. However, those rules do not apply, nor should they apply, where, as here, *the Court validly finds* that the plan administrator *did act* in an arbitrary and capricious manner. Under this scenario, *in a remand situation*, there exists no reason for the plan administrator to consider only that evidence which it had available to it at the time it made its original coverage decision (and, as here, "ignored")!

On pages 8 and 9 of its petition the petitioner states:

> This confinement of remand to consideration of evidence available at the time when the coverage decision was first made is all the more appropriate when it is considered that petitioner actually had the surgery in June, 1991, and that it failed . . .

The petitioner continues its discussion by noting that while the trial court herein relied upon the case of *Bucci v. Blue Cross-Blue Shield of Connecticut*, 764 F. Supp. 728, 732 (D. Conn. 1991), and that the Eleventh Circuit concluded reliance upon said case was reasonable:

> The Bucci court was not dealing with a remand situation . . .

See Petition at 9. Petitioner continues to seek to place the proverbial "square peg in the round hole." The result reached

here does *not* do injustice to any of the relied upon authorities (nor does it decide an important question of federal law which should be settled by this Court) as the facts of this case do not involve the District Court's consideration of any facts that the Plan Administrator (had or) did not have! As the trial court stated in its "Order" denying the petitioner's motion for new trial:

* * *

> Clearly, if the plan administrator failed to gather sufficient evidence in the course of rendering the first decision, the plan administrator cannot rely exclusively on that evidence in rendering the decision on remand. Rather, the plan administrator must gather enough additional evidence as is necessary to ground a reasonable decision. Moreover, on remand, the plan administrator is obligated to make a *new* determination — i.e., to make a determination as though no prior determination had been made. As a consequence, the plan administrator is obligated to consult all relevant evidence available up to the date of the new determination. Requiring the plan administrator to consult such evidence does not affect the plan administrator's discretion in rendering the decision on remand, it merely requires that the decision be reasonable in light of all the facts presently available.

(Resp. App. 31a).

The trial court clearly drew the distinction that the petitioner herein refuses to acknowledge exists, to wit: where, as here, a court, under a proper analysis, determines that the decision of a plan administrator *was* arbitrary, unreasonable, etc. and remands for reconsideration, *the plan administrator can (and should)*

consider all relevant evidence available up to the date of the new determination. Such a result does not collide with those settled principles of law which recognize that a trial court, in making the initial determination as to whether or not the plan administrator acted in an arbitrary or capricious manner, *cannot consider* evidence extrinsic to the initial determination. However, such is *not* the instant cause.

The trial court's analysis was correct. *If, in a de novo situation, a trial court can consider evidence the plan administrator did not have at the time of the initial determination, why then, in a remand situation, should the plan administrator be solely limited to the criteria in existence at the time of the initial (and arbitrary) decision*?

The respondent would respectfully suggest to this Court the opinion of the Eleventh Circuit, affirming as it does the trial court final judgment in favor of the respondent, is not in conflict with *either Cox* or *Bernards*. Likewise, the opinion does not present an important question of federal law which has not yet been settled, but should be settled, by this Court. As the petitioner's duty to provide benefits is a continuing one, the petitioner's refusal to provide benefits is thus a continuing denial, the propriety of which is measured against the information available from time to time. *See Bucci v. Blue Cross-Blue Shield of Connecticut, supra*. As a consequence the petition for writ of certiorari should be denied.

CONCLUSION

It is respectfully submitted that for the reasons stated herein it can be concluded that the petitioner has failed to demonstrate any conflict within the circuits and has further failed to demonstrate any compelling reason for this Court to exercise its discretion and to review this cause on the merits. The subject petition for writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

APPENDIX A — EXCERPTS OF TRANSCRIPT OF PROCEEDINGS DATED SEPTEMBER 21, 1992

[Commencing at Page 3]

MONDAY, SEPTEMBER 21, 1992, 10:09 A.M.

* * * * *

THE COURT: PRESENT YOUR CASE, MR. RATINER.

MR. RATINER: THANK YOU, YOUR HONOR.

YOUR HONOR, AT THIS TIME, THE PLAINTIFF WOULD LIKE I CALL AS AN ADVERSE WITNESS MISS MICKI KEENER.

THE COURT: MISS KEENER, WILL YOU PLEASE COME TO E STAND AND BE SWORN. THERE IS A DOOR OVER THERE THAT YOU JUST — THE COURTROOM SECURITY OFFICER WILL HELP YOU — IT PULLS OUT.

NOW, AGAIN, MA'AM, BE SEATED. WE HAVE ACOUSTICAL PROBLEMS HERE. THE CHAIR DOES NOT MOVE. YOU MUST SPEAK INTO THE MICROPHONE, HOWEVER, AS LOUDLY AS YOU CAN FOR EVERYONE TO BE ABLE TO HEAR.

I'M GOING TO HAVE YOU SWORN BY THE CLERK.

(MICKI L. KEENER, PLAINTIFF'S WITNESS, WAS SWORN.)

Appendix A

CROSS EXAMINATION

MR. RATINER:

Q. GOOD MORNING.

A. GOOD MORNING.

Q. CAN YOU HEAR ME ALL RIGHT?

A. YES.

Q. ALL RIGHT. IF YOU PULL THE MICROPHONE A LITTLE BIT CLOSER, I DON'T KNOW IF THAT'S POSSIBLE, HOW'S THAT?

[4] KENNER – CROSS

A. I'LL JUST SCOOT FORWARD.

THE COURT: DON'T BE UNCOMFORTABLE. AND IT MAY COME TO THE POINT THAT YOU MAY JUST HOLD THE MIKE AND SIT BACK. THAT CAN WORK — WHY DON'T YOU DO THAT?

CAN'T MOVE THAT ANY MORE. OKAY. THEY CHANGED THAT. THANK YOU. ALL RIGHT. LET'S SEE IF WE CAN TILT THAT UP THERE.

(DISCUSSION HAD OFF THE RECORD.)

THE WITNESS: CAN YOU HEAR ME?

Appendix A

THE COURT: YES, I CAN.

WILL YOU PLEASE TELL ME YOUR NAME AND HOW YOU. SPELL YOUR NAME.

THE WITNESS: MICKI KEENER, M-I-C-K-I K-E-E-N-E-R.

THE COURT: ALL RIGHT. NOW DIRECT YOUR ATTENTION TO MR. RATINER.

MS. DOLIN: YOUR HONOR, I'M SORRY, I CAN'T HEAR YOU.

THE COURT: DIRECT YOUR ATTENTION TO MR. RATINER.

MS. DOLIN: THANK YOU. I APOLOGIZE.

BY MR. RATINER:

Q. MA'AM, FOR THE RECORD, WILL YOU PLEASE IDENTIFY YOURSELF AND WHERE YOU LIVE?

A. MICKI KEENER, CLEARWATER, FLORIDA.

Q. AND WHAT IS YOUR AGE?

A. THIRTY-FIVE.

[5] Q. AND WHERE ARE YOU EMPLOYED?

A. WAS I EMPLOYED?

Appendix A

Q. WHERE ARE YOU EMPLOYED.

A. JACK ECKERD CORPORATION.

Q. IN WHAT CAPACITY?

A. MANAGER OF EMPLOYEE BENEFITS.

Q. ARE YOU ALSO THE PLAN MANAGER OF THE JACK ECKERD CORPORATION EMPLOYEE BENEFIT PLAN?

A. PLAN ADMINISTRATOR, YES.

Q. YOU ARE THE OFFICIAL PLAN ADMINISTRATOR?

A. YES.

Q. AND WHEN DID YOU FIRST TAKE ON THAT ROLE AS THE OFFICIAL PLAN ADMINISTRATOR FOR JACK ECKERD CORPORATION?

A. JUNE 1, 1990, AS THE PLAN ADMINISTRATOR OF THE JEC HEALTH BENEFITS PLAN.

Q. AND WHO WAS THE PLAN ADMINISTRATOR BEFORE YOU TOOK OVER?

A. TRAVELERS INSURANCE COMPANY.

Q. NOW, WHEN YOU TOOK OVER AS THE PLAN ADMINISTRATOR IN JUNE, WHAT WAS THE THEN EXISTING DEFINITION FOR TRANSPLANTATION OF ORGANS?

Appendix A

A. PRIOR TO JUNE 1, 1990 —

MS. DOLIN: OBJECT, JUDGE. THIS IS —

THE COURT: IT'S IRRELEVANT. SUSTAINED.

MS. DOLIN: HE ASKED HER —

[6] THE COURT: I KNOW WHAT HE ASKED HER AND I WILL SUSTAIN THE OBJECTION.

MS. DOLIN: THANK YOU. I CAN'T —

THE COURT: CAN YOU HEAR NOW?

MS. DOLIN: YES, NOW I CAN HEAR YOU.

BY MR. RATINER:

Q. AFTER YOU TOOK OVER AS THE PLAN ADMINISTRATOR, WAS THE DEFINITION, WHATEVER IT MAY HAVE BEEN BEFORE, CHANGED?

A. YES. EFFECTIVE JUNE 1, 1990, WE MADE SEVERAL PLAN CHANGES.

Q. AND WHAT WAS THE NEW DEFINITION THAT WAS APPLIED AS TO ENTITLEMENT TO ORGAN TRANSPLANTS?

A. TRANSPLANTS THAT WERE CONSIDERED EXPERIMENTAL OR INVESTIGATIVE, AS DETERMINED BY THE PLAN ADMINISTRATOR, WERE NOT COVERED.

Q. NOW, DID YOU HAVE ANY INPUT INTO THE CREATION OF THAT LANGUAGE?

A. NO.

Q. AS OF JUNE 1ST, WHEN YOU BECAME THE PLAN ADMINISTRATOR, DID YOU HAVE ANY MEDICAL BACKGROUND?

A. NO.

Q. DID ECKERD CORPORATION DIRECTLY EMPLOY ANY PHYSICIANS WHO WERE TRAINED IN THE FIELD OF TRANSPLANT MEDICINE?

A. NO.

Q. AS OF THE TIME THAT YOU TOOK OVER IN JUNE OF 1990, HAD [7] YOU EVER PREVIOUSLY HAD OCCASION TO HANDLE AN ORGAN TRANSPLANT CASE?

A. NO, SIR.

Q. BEFORE TOM SHANNON'S CLAIM, DID YOU EVER HAVE OCCASION CANDLE AN ORGAN TRANSPLANT CASE?

MS. DOLIN: OBJECTION, UNLESS IT'S LIMITED AS TO FRAME.

THE COURT: LET'S HAVE SOME REASONABLE PERIOD OF TIME.

YOU CAME ON BOARD WHEN, MA'AM?

THE WITNESS: I CAME ON BOARD IN MARCH OF '89 AND BECAME PLAN ADMINISTRATOR — I'M SORRY — YES, IN MARCH OF 1989 — AND BECAME PLAN ADMINISTRATOR IN JUNE OF 1989.

THE COURT: ALL RIGHT. DURING THAT PERIOD OF TIME.

MR. RATINER: YES, YOUR HONOR.

BY MR. RATINER:

Q. YOUR ANSWER?

A. I'M SORRY, WOULD YOU PLEASE —

THE COURT: DURING THAT PERIOD OF TIME, DID YOU KNOW OF ANY, DID YOU HAVE OCCASION TO BE INVOLVED IN ANY OTHER RENAL/PANCREAS TRANSPLANT PROCEDURES?

THE WITNESS: NO.

BY MR. RATINER:

Q. NOW, AS OF JUNE OF 1990, DID YOU HAVE ANY KNOWLEDGE OR [8] BASIS AS TO THE MEDICAL DEFINITION OF THE WORD "EXPERIMENTAL"?

A. MEDICAL DEFINITION?

Q. YES.

A. NO.

Q. DID YOU HAVE ANY KNOWLEDGE OF THE MEDICAL DEFINITION OF THE WORD "INVESTIGATIONAL"?

A. MEDICAL DEFINITION? NO, I DID NOT.

Q. NOW, IN JUNE OF 1990, WHEN THE PLAN WAS AMENDED FROM WHENEVER IT REQUIRED BEFORE THAT TO THE NEW LANGUAGE, DID THE PLAN ALSO HAVE A DEFINITION PAGE THAT WOULD PERMIT YOUR MEMBERS TO THUMB THROUGH YOUR PLAN AND TAKE A LOOK AT THE DEFINITION TO SEE WHAT IS MEANT BY THE WORD "EXPERIMENTAL," WHAT IS MEANT BY THE WORD "INVESTIGATIVE"?

MS. DOLIN: OBJECTION, IT'S BEEN ASKED AND ANSWERED.

MR. RATINER: THAT HAS NOT, YOUR HONOR.

MS. DOLIN: SHE —

THE COURT: OVERRULED.

A. NO.

Q. NOW, WHAT PROVISIONS DID THE PLAN OR YOU AS THE PLAN ADMINISTRATOR MAKE FOR THE BENEFIT OF YOUR BENEFICIARIES, OF THE PLAN MEMBERS FOR THEM TO UNDERSTAND WHETHER SOMETHING, A PARTICULAR PROCEDURE WAS OR WAS NOT COVERED?

A. (NO RESPONSE.)

* * *

[28] MR. RATINER: WE ARE INTRODUCING IT RIGHT NOW AS iLAINTIFF'S EXHIBIT NUMBER 2.

THE COURT: ALL RIGHT. IT'S TO BE INTRODUCED INTO HE RECORD AS NUMBER TWO, SO THE RECORD IS CLEAR.

MS. DOLIN: THE DEFENSE HAS NO OBJECTION.

(DISCUSSION HAD OFF THE RECORD.)

BY MR. RATINER:

Q. NOW, YOU'VE ALREADY SAID THAT YOU DID NOT CALL ANY OF THE OTHER INSURANCE COMPANIES OR OTHER PLAN ADMINISTRATORS ON THE LIST PROVIDED TO YOU BY DR. SUTHERLAND TO DETERMINE WHAT THEIR POSITION WAS ON PANCREAS TRANSPLANTS. JUST TO CONFIRM THIS, DID YOU-SEND OUT ANY LETTERS TO THEM OR MAKE ANY OTHER EFFORT AT COMMUNICATION WITH THEM?

A. NO.

Q. NOW, AFTER THIS LETTER CAME IN FROM COST CARE TO MISS AZEM IN WHICH SHE THEN APPARENTLY INCORPORATED INTO HER LETTER TO DR. SUTHERLAND, DID-YOU EVER PICK UP THE PHONE AND SPEAK TO ANYONE AT COST CARE ABOUT THE

Appendix A

PREDICATE FOR THE OPINIONS THAT ARE CONTAINED IN THE LETTER OF SEPTEMBER 7TH?

A. I WOULD NOT QUESTION THEIR MEDICAL OPINIONS, SIR.

Q. WELL, DID YOU EVER GIVE THEM A CALL AND ASK THEM, WELL, WHO DID YOU TALK TO, WHAT DID YOU READ? DID YOU EVER DO THAT?

A. I DON'T — I DIDN'T FEEL IT WAS APPROPRIATE.

Q. IS YOUR ANSWER NO?

[29] A. NO, NO.

Q. YOU DID NOT CALL THEM?

A. I DID NOT CALL THEM.

Q. ALL RIGHT. NOW, DID YOU EVER CALL UP DR. MARLOW AND SAY, DR. MARLOW — OR, FOR THAT MATTER, ANYBODY AT COST CARE — AND SAY PLEASE TELL ME WHAT DOES IT MEAN IN A MEDICAL CONTEXT WHEN A PROCEDURE IS EXPERIMENTAL? DID YOU EVER ASK THEM WHAT THAT MEANS?

MS. DOLIN: OBJECTION, IT'S BEEN ASKED AND ANSWERED.

THE COURT: SUSTAINED.

DON'T ANSWER THAT.

Appendix A

BY MR. RATINER:

Q. DID DR. MARLOW EVER PROVIDE YOU BY ANY OTHER DOCUMENTS OR MEANS WITH A DEFINITION FOR THE WORD "EXPERIMENTAL" OR INVESTIGATIONAL"?

A. NO.

Q. AND I TAKE IT YOU NEVER LOOKED UP THE TERMS "EXPERIMENTAL" OR "INVESTIGATIONAL" IN THE DICTIONARY, DID YOU?

A. THAT'S CORRECT.

Q. IN FACT, DID YOU IN THE DENIAL OF BENEFITS TO MR. SHANNON IN THIS INSTANCE BOW TO COST CARE'S JUDGMENT TO THIS REGARD?

A. NO.

[30] Q. AGAIN, YOUR DEPOSITION THAT WAS TAKEN ON JULY 10TH, 1991, AT PAGE NUMBER 73:

"QUESTION" — LINE FIVE — "BUT ULTIMATELY YOU ARE THE ONE WHO HAS TO MAKE THE CALL ON THE PROCEDURE, CORRECT?"

YOUR ANSWER: "I'M NOT A DOCTOR AND I DON'T PRESUME TO BE A DOCTOR, AND WHETHER OR NOT THIS DOCTOR'S WELL-REGARDED IN THIS AREA OR NOT, THAT'S NOT FOR ME TO DETERMINE, I CAN ONLY BOW TO COST CARE'S JUDGMENT."

DO YOU RECALL THAT QUESTION AND THAT ANSWER?

MS. DOLIN: JUDGE, I OBJECT. IT'S TAKEN TOTALLY OUT OF CONTEXT. AND I WOULD REQUEST THAT COUNSEL READ THE QUESTIONS PRECEDING IT.

THE COURT: FIRST ANSWER THAT QUESTION, MA'AM. ANSWER THAT QUESTION. DO YOU REMEMBER?

THE WITNESS: THE QUESTION WAS WHETHER I REMEMBER THAT QUESTION AND ANSWER? YES, I DO.

MR. RATINER: ALL RIGHT. I WILL READ THE PREVIOUS QUESTIONS IF THE COURT WISHES ME TO?

THE COURT: PLEASE DO.

MR. RATINER: I THINK 72, LINE 6.

MS. DOLIN: PAGE 72.

BY MR. RATINER:

Q. "NOW, UNDER YOUR PLAN, DO YOU HAVE, AS THE PLAN ADMINISTRATOR, THE DUTY TO DETERMINE WHETHER OR NOT CERTAIN BENEFITS ARE OR ARE NOT PAYABLE UNDER THE PLAN? YOU, IN [31] TURN, GO OUT AND HIRE CONSULTANTS OR OTHER PEOPLE TO TRY TO ADVISE YOU, IS THAT CORRECT?

"ANSWER: CORRECT.

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"QUESTION: NOW IN THIS INSTANCE, YOU HAD A LETTER, A DOCUMENT FROM DR. SUTHERLAND, DAVID SUTHERLAND AT THE UNIVERSITY OF MINNESOTA, IN WHICH HE INDICATED TO YOU THAT A KIDNEY/ PANCREAS TRANSPLANT IS AN ACCEPTABLE PROCEDURE AND IS NOT IN ANY WAY INVESTIGATIVE OR EXPERIMENTAL. DID YOU MAKE ANY EFFORT TO ASCERTAIN WHO DR. SUTHERLAND WAS OR HIS STATUS IN THE MEDICAL COMMUNITY THAT WOULD GIVE HIM THE CREDENTIALS TO MAKE SUCH A STATEMENT?"

YOUR ANSWER: "I DID NOT.

"QUESTION: DO YOU KNOW IF ANYONE DID?

"ANSWER: I DON'T KNOW.

"QUESTION: NOW, IF DR. SUTHERLAND HAD MINIMAL QUALIFICATIONS OR CREDENTIALS IN THIS AREA OR THE AREA OF TRANSPLANT PROCEDURES, WOULD THAT BEAR UPON YOUR DECISION IN, YOU MIGHT SAY, NOT PAYING TOO MUCH ATTENTION TO HIS RECOMMENDATIONS?

"ANSWER: THAT WOULD BE DR. MARLOW'S OR COST CARE'S."

DO YOU REMEMBER THOSE QUESTIONS AND THOSE ANSWERS?

MS. DOLIN: EXCUSE ME. I WANT YOU TO READ THE NEXT, TOO, PLEASE.

[32] BY MR. RATINER:

Q. "QUESTION" — THAT WAS READ BEFORE — "BUT ULTIMATELY YOU ARE THE ONE WHO HAS TO MAKE THE CALL ON THE PROCEDURE, CORRECT?

"ANSWER: AGAIN, I AM NOT A DOCTOR AND I DON'T PRESUME TO BE A DOCTOR, AND WHETHER OR NOT THIS DOCTOR IS WELL-REGARDED IN THIS AREA OR NOT, THAT'S NOT FOR ME TO DETERMINE, I CAN ONLY BOW TO COST CARE'S JUDGMENT."

WERE THOSE YOUR ANSWERS TO THOSE QUESTIONS?

A. YES, SIR.

Q. NOW, I KNOW THAT YOU HAVE ANSWERED MY QUESTION CONCERNING YOUR NOT CONTACTING ANY OF THE DOCTORS THAT WERE ON THE JOURNAL ARTICLES PROVIDED TO YOU BY DR. SUTHERLAND.

OTHER THAN — WELL, STRIKE THAT.

DID YOU CONTACT OR TALK TO ANY OTHER DOCTORS, WHATSOEVER, WHO DO PANCREAS TRANSPLANTS, EITHER IN FLORIDA OR THE UNITED STATES OR ANYWHERE IN THE WORLD TODAY TO GET THEIR OPINIONS OR THEIR DEFINITIONS AS TO WHETHER OR NOT A PANCREAS TRANSPLANT WAS CONSIDERED TO BE EITHER EXPERIMENTAL OR INVESTIGATIONAL?

MS. DOLIN: OBJECTION. IT GOES BEYOND THE TIME FRAME. IT HAS — IT'S IRRELEVANT, THEREFORE, IT HAS TO BE CONFINED TO THE TIME SHE MADE HER DECISION AND HE SAID TODAY.

THE COURT: AT THE TIME YOU MADE YOUR DECISION, . . .

* * *

[34] REVIEW IN FURTHERANCE OF THE APPELLATE PROCESS?

A. NO. COST CARE HAD RENDERED THE MEDICAL OPINION. AT THAT POINT IN TIME, I CONTACTED OTHER INSURANCE COMPANIES IN THE COMMUNITY TO FIND OUT THEIR HANDLING OF SUCH PROCEDURES.

Q. AND YOU CONTACTED WHO?

A. HUMANA, BLUE CROSS AND BLUE SHIELD OF FLORIDA; THE CONSULTANT CONTACTED JOHN HANCOCK.

Q. AND, OF COURSE, AS TO HUMANA AND BLUE CROSS, YOU NEVER RECEIVED ANY WRITTEN DOCUMENTATION FROM THEM, DID YOU?

A. THAT'S CORRECT.

Q. NOW, WITH REFERENCE TO YOUR PLAN CONTRACT WITH COST CARE, ISN'T IT TRUE THAT COST CARE WAS SUPPOSED TO PROVIDE SOME PROCEDURE FOR AUTOMATIC REVIEWS OF THESE MATTERS —

THE COURT: NOW, THAT'S —

BY MR. RATINER:

Q. WITH THE AMOUNT OF BENEFITS?

THE COURT: — THAT'S AN IRRELEVANT ISSUE, MR. RATINER.

MR. RATINER: YOUR HONOR, IT'S THE PLAINTIFF'S POSITION THAT IF COST CARE, AS THE AGENT OF ECKERD, DEVIATED FROM ACCEPTED PROCEDURE, THIS WOULD BE EVIDENCE THAT SHOULD BE HEARD BY THE COURT.

THE COURT: THE CONTRACT BETWEEN COST CARE AND ECKERD IS NOT RELEVANT.

* * *

[36] MR. RATINER.

BY MR. RATINER:

Q. WELL, DID YOU ASSUME THAT COST CARE WOULD CONDUCT AN APPELLATE REVIEW?

MS. DOLIN: OBJECTION, SAME OBJECTION.

THE COURT: OBJECTION SUSTAINED.

DON'T ANSWER THAT, MA'AM.

BY MR. RATINER:

Q. WAS APPELLATE REVIEW ONE OF THE RIGHTS THAT MR. SHANNON HAD UNDER HIS PLAN?

THE COURT: YOU MAY ANSWER THAT.

A. THERE WAS A REVIEW PROCESS, YES.

MR. RATINER: DAVE, LET ME HAVE THE PLAN, PLEASE.

YOUR HONOR, AT THIS TIME, WE WOULD LIKE TO INTRODUCE A COPY OF THE ECKERD PLAN.

THE COURT: LET'S SEE. IS THERE ONE IN THE COURT FILE ATTACHED TO THE COMPLAINT?

MS. DOLIN: JUDGE, THERE IS. WELL, IT'S ACTUALLY ATTACHED TO THE ANSWER. I HAVE A FRESH XEROX FROM THE ORIGINAL DOCUMENT IF YOUR HONOR WOULD PREFER.

THE COURT: YES. GIVE ME THAT HERE, PLEASE, AND THEN YOU CAN USE THAT.

THE PLAN SHOULD BE IN AS PLAINTIFF'S EXHIBIT NUMBER 3.

MS. DOLIN: JUDGE, THIS IS, IN FACT, A COPY OF THE . . .

* * *

[40] MS. DOLIN: SAME OBJECTION. AND, IN ADDITION, IT'S OVERBROAD. AND IT ALSO PRESUMES TO ASK FOR A LEGAL CONCLUSION WITHIN THE CONFINES OF ERISA.

THE COURT: I'M GOING TO OVERRULE THE OBJECTION.

IF IT CAME TO YOUR ATTENTION THAT THERE WAS SOME ERROR IN COST CARE'S METHODOLOGY OF DETERMINING THE CLAIM, WOULD YOU HAVE TAKEN ANY ACTIONS AS A RESULT OF THAT?

THE WITNESS: BY "ACTION," DO YOU MEAN CHANGE OUR DECISION?

THE COURT: SOME ACTIONS, FOLLOWED UP ON IT.

MS. DOLIN: JUDGE, I HAVE ALSO GOT TO OBJECT ON THE BASIS OF TIME.

THE COURT: PRIOR TO THE TIME THAT ECKERD MADE ITS DECISION.

THE WITNESS: I FRANKLY DON'T KNOW THE ANSWER TO THAT QUESTION.

BY MR. RATINER:

Q. WELL, IF YOU KNEW THAT COST CARE DID NOTHING — LET'S ASSUME HYPOTHETICALLY YOU

HAD DEFERRED TO COST CARE, AND YOU THEN FOUND OUT THAT COST CARE WAS A COMPLETE FRAUD, THEY DIDN'T HAVE DOCTORS THERE WHO WERE QUALIFIED, YOU FOUND OUT THAT THEY HAD PEOPLE THERE WHO DIDN'T HAVE ANY EXPERTISE WHATSOEVER IN HANDLING THIS KIND OF STUFF, WHAT WOULD YOU HAVE DONE?

MS. DOLIN: JUDGE, THE SAME OBJECTION AS I MADE

* * *

[46] (RECORD READ.)

A. THE MEDICAL CRITERIA, YES, THAT IS CORRECT.

Q. NOW, WHAT COST CARE CRITERIA ARE YOU REFERRING TO?

A. WHATEVER CRITERIA COST CARE HAS IN ITS POSSESSION TO RENDER ADVICE IN SITUATIONS LIKE THIS.

Q. WELL, YOU HAD TRAVELERS' CRITERIA AND YOU SAID YOU WOULDN'T USE THAT BECAUSE OF COST CARE'S CRITERIA. PLEASE TELL ME, DID YOU HAVE COST CARE'S CRITERIA THERE TO COMPARE IT WITH?

A. NO, IT WASN'T MY JOB TO HAVE THEIR CRITERIA.

Q. DID YOU EVER CALL UP COST CARE AND ASK THEM AS THE PERSON WHO HAS TO MAKE THE DECISION IN

THIS CASE, SHOW ME YOUR CRITERIA FOR YOUR DECISION?

MS. DOLIN: OBJECTION.

THE COURT: I'M GOING TO OVERRULE THE OBJECTION.

YOU MAY ANSWER THAT.

A. NO. WHAT I NEEDED FROM COST CARE WAS THEIR BOTTOM LINE MEDICAL DETERMINATION IN THIS PARTICULAR CIRCUMSTANCE.

Q. WELL, YOU HAD A RESPECTED COMPANY, TRAVELERS, THAT GAVE YOU THEIR CRITERIA. YOU DIDN'T HAVE YOUR OWN CRITERIA, YOU, ECKERD. YOU SAID YOU RELIED UPON COST CARE'S CRITERIA. YOU DIDN'T KNOW WHAT COST CARE'S CRITERIA IS AND YOU DIDN'T BOTHER TO ASK THEM, BECAUSE I THINK YOU SAID THAT WASN'T YOUR BUSINESS, IS THAT RIGHT?

A. IT'S NOT MY BUSINESS TO QUESTION THE MEDICAL CRITERIA . . .

* * *

[71] BEEN ASKED AND ANSWERED.

THE COURT: OVERRULED.

ANSWER THE QUESTION, PLEASE.

Appendix A

A. COST CARE PROVIDED THE MEDICAL ADVICE HERE. I OBTAINED THE INSURANCE COMPANY INFORMATION FOR A DIFFERENT PURPOSE.

MR. RATINER: YOUR HONOR, CAN I HAVE AN ANSWER TO MY QUESTION?

BY MR. RATINER:

Q. MY QUESTION WAS: DID YOU — DID COST CARE — I'M SORRY — DID YOU, DID ECKERD CONTACT ANY PANCREAS TRANSPLANTATION PERFORMING PHYSICIANS ANYWHERE TO ASK THEM JUST THE SIMPLE QUESTION: DO YOU CONSIDER THIS PROCEDURE TO BE EXPERIMENTAL OR INVESTIGATIONAL?

MS. DOLIN: OBJECTION, RELEVANCY, AND ASKED AND ANSWERED.

THE COURT: ALL RIGHT. JUST ANSWER IT AGAIN, MA'AM. YOU DID NOT?

A. NO.

THE COURT: SHE'S ANSWERED THAT BEFORE, MR. RATINER. MISS DOLIN IS RIGHT ABOUT THAT. THAT WAS ANSWERED THIS MORNING.

MR. RATINER: YOUR HONOR, I WOULD LIKE TO INTRODUCE INTO EVIDENCE FOUR LETTERS THAT ARE RELEVANT AND MATERIAL TO THE CONSIDERATION OF THE DEPOSITIONS OF DR. MARLOW, WHOSE TESTIMONY WILL HAVE TO BE TAKEN BY YOUR . . .

Appendix A

* * *

[75] REDIRECT EXAMINATION

BY MS. DOLIN:

Q. NOW, MISS KEENER, ON DIRECT EXAMINATION YOU TESTIFIED, I BELIEVE, THAT THE PLAN PROVIDES DISCRETION TO THE PLAN ADMINISTRATOR TO DECIDE WHAT IS EXPERIMENTAL OR INVESTIGATIONAL IN THE WAKE —

MR. RATINER: YOUR HONOR, I HAVE TO OBJECT. I DON'T RECALL THAT TESTIMONY COMING FROM THIS WITNESS.

MS. DOLIN: IT'S ONE OF THE FIRST THINGS HE ASKED HER, JUDGE.

THE COURT: THE OBJECTION IS OVERRULED.

MS. DOLIN: THANK YOU.

BY MS. DOLIN:

Q. THAT THE PLAN DOES PROVIDE THAT THE PLAN ADMINISTRATOR HAS DISCRETION TO DETERMINE WHICH OF THOSE HUMAN ORGAN TRANSPLANTS ARE, IN FACT, EXPERIMENTAL OR INVESTIGATIONAL. DO YOU REMEMBER THAT TESTIMONY?

A. YES.

Q. ISN'T IT TRUE, MISS KEENER, THAT IN MAKING THAT DETERMINATION, THOSE DETERMINATIONS HAVE TO BE DONE ON A CASE-BY-CASE BASIS BASED ON THE FACTS AVAILABLE?

A. THAT'S RIGHT.

Q. NOW, ISN'T IT IN FACT TRUE THAT MR. SHANNON'S PRE-CERTIFICATION REQUEST CALLED FOR THE PLAN TO MAKE SUCH A . . .

* * *

[111] KEENER – RECROSS

BY MR. RATINER:

Q. DID YOU MAKE ANY EFFORT TO FIND OUT WHETHER ANYONE ELSE AGREED WITH YOUR DEFINITIONS?

A. NOT WITH MY WORKING DEFINITION.

Q. AND YOU HAD NO OTHER DEFINITION, RIGHT?

A. I DIDN'T NEED ANYTHING MORE THAN MY WORKING DEFINITION.

Q. DID YOU EVER MAKE ANY ATTEMPT TO FIND OUT WHETHER THERE WAS ANYONE ELSE IN THIS WHOLE WIDE WORLD WHO AGREED WITH YOUR WORKING DEFINITION?

A. I DIDN'T SEE ITS RELEVANCY.

Q. DID YOU EVER MAKE ANY EFFORT OR ATTEMPT TO FIND OUT IF THERE WAS ANYONE ELSE IN THE WHOLE WORLD WHO AGREED WITH YOUR WORKING DEFINITION OF WHAT WAS EXPERIMENTAL OR INVESTIGATIONAL?

MS. DOLIN: JUDGE, THAT IS IRRELEVANT. ACCORDING TO THE TERMS OF THE PLAN, WHICH GIVE THE PLAN ADMINISTRATOR THE DISCRETION TO DEFINE THOSE TERMS.

THE COURT: CORRECT. BUT I'M GOING TO OVERRULE THE OBJECTION.

BY MR. RATINER:

Q. MA'AM, COULD I HAVE AN ANSWER, PLEASE?

A. MAY I HAVE THE QUESTION AGAIN, PLEASE?

MR. RATINER: READ IT BACK, PLEASE.

THE COURT: DID YOU COMPARE YOUR WORKING DEFINITION OF EXPERIMENTAL WITH ANYONE ELSE?

[112] THE WITNESS: NO.

BY MR. RATINER:

Q. NOW, WHAT WAS THE REASON WHY THE PLAN DID NOT CONTAIN IN THEIR DEFINITION SECTION EVEN

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YOUR WORKING DEFINITION OF WHAT WAS EXPERIMENTAL OR INVESTIGATIONAL?

THE COURT: SUSTAINED.

MS. DOLIN: OBJECT.

THE COURT: SHE DOESN'T KNOW WHY THE PLAN DIDN'T INCLUDE SOMETHING. SUSTAINED.

BY MR. RATINER:

Q. NOW, AS OF OCTOBER 11TH, THE DATE THAT THE DENIAL LETTER WENT OUT — LET ME CLARIFY THIS, IF I MAY. THE DENIAL LETTER OF OCTOBER 11TH WAS BASED PRIMARILY UPON THE LETTER FROM DR. MARLOW, CORRECT?

A. NO.

Q. NO.

YOU REMEMBER PAGE 34 OF YOUR DEPOSITION?

MS. DOLIN: JUDGE, THIS HAS BEEN ASKED AND ANSWERED SEVERAL TIMES. WE HAVE BEEN OVER THIS AD NAUSEAM.

MR. RATINER: THE WITNESS JUST GAVE ME A DIAMETRICALLY OPPOSED RESPONSE FROM DIRECT EXAMINATION NOW TO REDIRECT. I THINK I HAVE GOT TO CLARIFY THAT.

MS. DOLIN: IT IS THE SAME ANSWER SHE GAVE YOU ON DIRECT AND SHE CLARIFIED IT ON CROSS. WE DON'T HAVE TO KEEP GOING OVER THIS.

* * *

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA FILED MARCH 22, 1993

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff,

vs.

JACK ECKERD CORPORATION,

Defendant.

ORDER

This cause comes before the Court upon Defendant Jack Eckerd Corporation's ("Eckerd") Motion for a New Trial. After due consideration, Eckerd's motion is DENIED. While the contentions Eckerd advances were addressed in the Court's Findings of Fact and Conclusions of Law, issued November 18, 1992. The present Order seeks to clarify any ambiguity that may have been raised by the Order of November 18, 1992.

In its Findings of Fact and Conclusions of Law, the Court found that the Plan Administrator of the Jack Eckerd Corporation Health Plan ("the Plan") based her decision to deny Plaintiff Thomas Shannon's ("Shannon") claim for benefits covering a renal/pancreas transplant on the following three criteria: 1) the fact that Medicare denied payment for Shannon's claim, 2) the fact that Eckerd's medical review consultant — Cost Care, Inc.

("Cost Care") — advised her that the pancreas transplant procedure was regarded as investigational by the medical community, and 3) the fact that a number of insurance companies classified the procedure as investigational. The Court determined that the Plan Administrator failed to adequately investigate any of these criteria and that her decision to deny Shannon's claim was therefore "arbitrary and capricious". In accordance with this determination, the Court remanded the case to the Plan Administrator for a new determination concerning Shannon's entitlement to benefits for the renal/pancreas transplant that he underwent in 1991.

In support of its determination that the Plan Administrator failed to adequately investigate the medical status of the pancreas transplant procedure, the Court found that the October 27, 1990 from Dr. Thomas Sutherland — Shannon's treating physician — to the Plan Administrator constituted notice to the Plan Administrator that Cost Care's conclusion that the procedure was investigational may not have been well founded. Eckerd contends that the information referenced in the letter had already been transmitted to Cost Care by the time the Plan Administrator received the letter and that the Plan Administrator was aware of this transmission. Even if this contention is correct, it is irrelevant. The fact that one of the nation's leading authorities on pancreas transplants raised significant objections to Cost Care's conclusion should have induced the Plan Administrator to either question Cost Care as to the basis for its conclusion or to engage a second medical consultant for another evaluation. The Plan Administrator did neither.

Eckerd also contends that the Court's determination that the Plan Administrator failed to adequately investigate the meaning of the term "investigational" within the insurance industry was improper for two reasons. First, the Court did not

define "what a consensus within the insurance community would be," but nevertheless concluded that the Plan Administrator failed to consult a number of insurance companies sufficient to reflect such a consensus. Second, the Court speculated as to the reasons why several of the insurers consulted by the Plan Administrator classified the pancreas transplant procedure as investigational.

Both of Eckerd's contentions lack merit. Eckerd's first contention reveals a misunderstanding of the nature of the Court's determination. The Court determined that *the Plan Administrator* made no effort to ensure that her survey of the views of the insurance community was sufficient to reveal a consensus within that community. It is not necessary for the Court to define what would constitute such a consensus in order to find that the Plan Administrator failed to take any steps to ensure that the responses from the insurers that she contacted reflected a consensus.

Eckerd's second contention also lacks merit. In its Findings of Fact and Conclusions of Law, the Court concluded that reliance on the bare fact that a particular insurer classified the pancreas transplant procedure as investigational, absent any inquiry concerning the reasons underlying this classification, was not reasonable. This conclusion becomes inescapable in view of the grounds upon which an insurer might chose to classify a procedure as investigational. One of the insurance company's contacted by the Plan Administrator might classify the pancreas transplant procedure as investigational because, under the terms of its plans, *all* transplant procedures are classified as investigational. The Plan Administrator had already determined that Eckerd's Plan covered renal transplants and therefore that the Plan covered *some* transplant procedures. The insurance company's classification decision would thus provide no guidance concerning whether to classify the pancreas

transplant procedure as investigational under the terms of Eckerd's Plan[1].

Eckerd also objects to the Court's requirement that, in making a new determination on remand, the Plan Administrator consider all relevant evidence available up to the date of the new determination. All of the relevant decisional authority on point is consistent with this proposition. In *Jett v. Blue Cross and Blue Shield of Alabama,* 890 F.2d 1137 (11th Cir. 1989), for instance, the Eleventh Circuit quoted a Seventh Circuit decision for the proposition that:

> As a general matter a court should not resolve the eligibility question on the basis of evidence never presented (to an ERISA plan's administrator) but should remand to the (administrator) for a new determination.

This language clearly prohibits the *district court* from considering evidence not presented to an ERISA plan administrator when reviewing the administrator's decision under the arbitrary and capricious standard. To allow the district court to consider such evidence would convert review under the arbitrary and capricious standard into *de novo* review[2]. Nothing

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1. The Court engages in "speculation" here to demonstrate that the relevance of the information provided to the Plan Administrator by the insurance companies that she contacted, and thus the reasonableness of her reliance on that information, turn on the reasons why the insurers classified the pancreas transplant procedure as they did. In this light, the Plan Administrators failure to inquire as to these reasons was clearly unreasonable.

2. All of the cases cited by Eckerd simply preclude the *district court,* not the plan administrator, from considering new evidence.

in the quoted language, however, suggests that a plan administrator to is not obligated to consider this evidence. To the contrary, the purpose of remand is to provide the plan administrator with the opportunity to consider the evidence.

Berry v. Ciba-Geigy Corp., 761 F.2d 1003 (4th Cir. 1985) provides the clearest expression of this position. In *Berry*, a case cited with approval by both the Eleventh Circuit and Eckerd, the Fourth Circuit explained that:

> While it is open to the trial judge to consider whether . . . (the plan administrator) erred in not securing sufficient evidence on which to base a termination decision, it was error for the court to admit into evidence . . . after the fact testimony . . . If the court believed the administrator lacked adequate evidence, the proper course was to 'remand to the trustees for a new determination.'. . .

Clearly, if the plan administrator failed to gather sufficient evidence in the course of rendering the first decision, the plan administrator cannot rely exclusively on that evidence in rendering the decision on remand. Rather, the plan administrator must gather enough additional evidence as is necessary to ground a reasonable decision. Moreover, on remand, the plan administrator is obligated to make a *new* determination — i.e., to make a determination as though no prior determination had been made. As a consequence, the plan administrator is obligated to consult all relevant evidence available up to the date of the new determination. Requiring the plan administrator to consult such evidence does not affect the plan administrator's discretion in rendering the decision on remand, it merely requires that the decision be reasonable in light of all the facts presently available.

DONE and ORDERED, in chambers, Miami, Florida, this 22 day of March 1993.

s/ Lenore C. Nesbitt
LENORE C. NESBITT
UNITED STATES DISTRICT JUDGE

cc: counsel of record

APPENDIX C — ORDER OF REMAND OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA FILED NOVEMBER 16, 1992

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 91-0271-CIV-NESBITT

THOMAS SHANNON,

Plaintiff,

vs.

JACK ECKERD CORPORATION,

Defendant.

ORDER OF REMAND

This cause was tried before this Court during the week of September 21, 1992. Having reviewed all of the evidence properly presented at trial, and all of the applicable law, it is hereby

ORDERED and ADJUDGED that, consistent with the Findings of Fact and Conclusions of Law entered this day, this matter is remanded to the Plan Administrator of the Jack Eckerd Corporation Health Plan ("the Plan") for a new determination concerning whether Shannon is entitled to benefits under the Plan covering the combined kidney/pancreas transplant procedure that Shannon underwent in 1991, and it is further

ORDERED and ADJUDGED that the Court deems this Order of Remand to be a proper request for review of the denial

of Shannon's claim for the aforementioned benefits[1]. As a consequence, the Plan Administrator's decision on remand shall be governed by the provisions of 29 C.F.R. § 2560.503-1(h). In accordance with that regulation, the Plan Administrator shall make this decision within sixty days from the date of this Order, unless the Plan Administrator can detail special circumstances which warrant an extension of time. If such circumstances do prevail, the Plan Administrator shall make the decision no later than 120 days after the date of this Order. It is further

ORDERED and ADJUDGED that Shannon's claim for a declaration of his entitlement to future benefits under the Plan covering a second pancreas transplant is DENIED as Shannon has failed to exhaust his administrative remedies with respect to this claim.

DONE and ORDERED, in chambers, Miami, Florida, this 18th day of November 1992.

s/ Lenore C. Nesbitt
LENORE C. NESBITT
UNITED STATES DISTRICT JUDGE

cc: counsel of record

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1. By characterizing the procedure required by this Order as a "review," the Court does not wish to suggest that the Plan Administrator may confine his or her analysis concerning whether a pancreas transplant is experimental or investigational to the evidence available at the time of the original denial. Rather, prior to rendering his or her decision on remand, the Plan Administrator must make a reasonable inquiry into all pertinent evidence available up to the date of that decision. *See Bucci v. Blue Cross-Blue Shield of Conn.*, 764 F.Supp. 728, 732 (D.Conn. 1991) ("[D]efendant's duty to provide benefits is a continuing one, its refusal to provide benefits is thus a continuing denial, the propriety of which is measured against the information available from time to time. The information is not static, but is developing.").